

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician, and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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4610  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
05887

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 1 hour 50 mins.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 3405 Tilden St.		46	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS Brentwood, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy Austin		First Middle Last		4. DATE OF DEATH April 21 1961		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 21, 1961	
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Warren Austin				14. MOTHER'S MAIDEN NAME Jane Lula Booher			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give number and date of service)		17. INFORMANT Mother		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7735 DUE TO Respiratory Failure (b) Underdeveloped Resp. Centers (c) Immaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 21, 1961 to April 21, 1961, that (I) (we) last saw the deceased alive on April 21, 1961, and that death occurred at 2:55 p.m. the causes and on the date stated above.							
22a. SIGNATURE Dr. William R Greco. M.D.		22b. DATE SIGNED Apr. 25, 1961		22c. PHYSICIAN'S NAME (Type) Dr. William R Greco. M.D.		22d. ADDRESS 2211 University Bulovard East Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5/12/61		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town or county) (State) Cheverly, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr.				25a. REC'D BY REGISTRAR MAY 15 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thane	

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James L. Cooper

William Green Smith

James as above

John

James L. Cooper

William Green Smith

1/1

James L. Cooper

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James L. Cooper

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	
c. LENGTH OF STAY IN 1b <i>21 days</i>		d. STREET ADDRESS <i>12015 - Tuckerman St</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Leland Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Catherine M. Baum</i>		4. DATE OF DEATH Month <i>4</i> Day <i>16</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/30/85</i>
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>District of Columbia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Samuel Brunner</i>		14. MOTHER'S MAIDEN NAME <i>unborn</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Hennorne Baum, same as #2</i>		Address <i>same as #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular failure</i> 900.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Inter capsular fracture of right femur</i> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Dissecting aortic aneurysm</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <i>no</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell on a step in a pebbles restaurant</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>3</i> p.m. <i>3-26-1961</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Restaurant</i>	20f. (City or town) (County) (State) <i>Arlington, Arlington Va</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James I. Boyd</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>James I. Boyd</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <i>4-12-61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/19/1961</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>	22d. LOCATION (City, town, or country) (State) <i>Arlington, Virginia</i>
23. FUNERAL DIRECTOR <i>The S. H. Harris Co.</i>		24a. REC'D BY REGISTRAR <i>APR 19 '61</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>			

MEDICAL CERTIFICATION

M

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1913

(M)

(I)

First Name

Last Name

Age

Sex

Place of Birth

Occupation

Marital Status

Color

Build

Height

Weight

Date of Death

Time of Death

Place of Death

Cause of Death

Manner of Death

Signature of Examiner

Signature of Physician

Medical History

Physical Examination

Post-mortem Examination

Death I. 1913

1913

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4613											
CERTIFICATE OF DEATH											
04602											
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 306 1/2 Montgomery St						d. STREET ADDRESS 306 1/2 Montgomery St					
3. NAME OF DECEASED (Type or print) Florence Bryan Bell						4. DATE OF DEATH April 26 1961					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 28 1882		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Elizabethtown, Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hillary Brown						14. MOTHER'S MAIDEN NAME Sallie Mc Donald					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Sallie Canadian, Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Hypertension 420.0 DUE TO (b) Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arterio-sclerosis Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 11:30 p.m. Month, Day, Year April 26 1961						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11:30 p.m. to 11:30 p.m., that (I) (we) last saw the deceased alive on April 26 1961, and that death occurred at 11:30 p.m. from the causes and on the date stated above.											
22a. SIGNATURE Robert C. Wingfield						M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED April 27 1961	
22c. PHYSICIAN'S NAME (Type) ROBERT C. WINGFIELD						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/2/61		23c. NAME OF CEMETERY OR CREMATORY St James Cemetery				23d. LOCATION (City, town or county) (State) Elizabethtown Kentucky	
24. FUNERAL DIRECTOR'S SIGNATURE R. W. With Canadian, Laurel, Md.						ADDRESS		25a. REC'D BY REGISTRAR MAY 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kincaid	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4614

04603

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>26 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Deale</b> d. STREET ADDRESS <b>02X-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Dorothea</b> <b>Berlitz</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>28</b> Year <b>1961</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>3-4-07</b>		<b>9. AGE</b> (In years last birthday) <b>54 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>54</b> Days <b>54</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Philadelphia Pa</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>					
<b>13. FATHER'S NAME</b> <b>FRANCIS ROGERS ELLIS</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Marian Gertrude Nagel</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>154X</b>		<b>17. INFORMANT</b> <b>Eus Berlitz Deale, Md.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, rectum</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>154X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 yrs</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>1746 K St N.W. Wash DC</b>			
<b>20f. (City or town)</b> <b>Wash DC</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from April 3, 1961 to April 28, 1961, that (I) (we) last saw the deceased alive on April 28, 1961, and that death occurred 9:20 p.m. the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Donald W. Mitchell</b>		<b>22b. DATE</b> <b>April 28, 1961</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Donald W. Mitchell</b>			
<b>22d. ADDRESS</b> <b>1746 K St N.W. Wash DC</b>		<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22f. SIGNATURE</b> <b>Arthur S. Thomas</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>MAY 2 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Hillcrest Memorial</b>			
<b>23d. LOCATION (City, town or county)</b> <b>ANNAPOLIS Md</b>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>T A Hardesty &amp; Son</b>		<b>24a. ADDRESS</b> <b>Galesville, Md.</b>		<b>24b. REC'D BY REGISTRAR</b> <b>MAY 2 '61</b>			
<b>24c. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>		<b>24d. DATE</b> <b>MAY 2 '61</b>		<b>24e. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>			

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Francis Rogers Ellis

Philip A. Phillips  
Mrs. Bertha D. Phillips

T. A. Woodbury in Colonial  
Pierre Marais Hillcrest Memorial  
Linn County Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/59

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4615  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
04604

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b> d. STREET ADDRESS <b>Landover Road Box 199</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>George O. Bickley</b>				4. DATE OF DEATH Month Day Year <b>April 4 1961</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-27-79</b>		9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>				11. BIRTHPLACE (State or foreign country) <b>Illinois</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>William Bickley</b>						14. MOTHER'S MAIDEN NAME <b>Mary Warner</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>Harriet Snyder</b>				Address <b>As Above #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO <b>1</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Broncho pneumonia</b>												INTERVAL BETWEEN ONSET AND DEATH <b>14</b> <b>year</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 1 1961</b> to <b>April 4 1961</b> , that (I) (we) last saw the deceased alive on <b>April 4 1961</b> , and that death occurred at <b>9:35 p.m.</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>Till Bergeman</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <b>Till Bergeman, M.D.</b>				22d. ADDRESS <b>4314 Gallatin St. Hyattsville, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/8/61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 10 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

OFFICE OF DEATH

1913

(M)

NAME OF DECEASED  
RESIDENCE  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
AGE  
SEX  
MARRIAGE

DATE OF BURIAL  
PLACE OF BURIAL  
NAME OF FUNERAL HOME  
NAME OF MINISTER  
NAME OF CEMETERY  
NAME OF INTERVIEWER  
NAME OF WITNESS  
NAME OF CLERK  
NAME OF DECEASED'S NEXT OF KIN

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(M)

077

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4616

04605

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>16 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park Md</b> d. STREET ADDRESS <b>5004 Laguna Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Amos</b>		First		Middle		Last <b>Blum</b>		4. DATE OF DEATH <b>April 4 1961</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/26/09</b>		9. AGE (In years last birthday) <b>51 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Henry Blum</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Miller</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>Ruth C Blum</b>				Address <b>College Park, Maryland.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Rheumatic Heart Disease.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>5 yrs.</b> <b>5 yrs.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>College Park, Md.</b>		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4-3</b> , 19 <b>61</b> to <b>4-4</b> , 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>4-4</b> , 19 <b>61</b> , and that death occurred at <b>3:05 PM</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>H. David Kerr, M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>9812 49th Ave. College Park, Md.</b>				22b. DATE SIGNED <b>4-4-61</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>April 7, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Pittsburg, Pennsylvania</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>					

VR A15 (4)  
15M 9/60



1. Busch's Sons Hydraulic, St. Louis, Mo.  
April 7, 1901, delivery of order to  
Pittsburgh, Pennsylvania

0812 West Ave. College Park, Md.

3/21/01

4-1-01

*Handwritten notes and signatures, including "Wm. H. Busch" and "J. H. Busch".*

0812 West Ave. College Park, Md.

William Miller

U.S. Government

John I. Miller

Chemist

Henry H. Miller

0812

110

*Handwritten signature.*

4/1/01

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4617

04606

<b>1. PLACE OF DEATH</b> a. COUNTY <p style="text-align: center; font-size: 1.2em;">Prince Georges</p> <p style="text-align: center; font-size: 0.8em;">MARYLAND</p> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <p style="text-align: center; font-size: 1.2em;">Glenn Dale (RURAL)</p> c. LENGTH OF STAY IN 1b <p style="text-align: center; font-size: 1.2em;">93 days</p> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <p style="text-align: center; font-size: 1.2em;">Glenn Dale Hospital</p>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <p style="text-align: center; font-size: 1.2em;">D.C.</p> b. COUNTY <p style="text-align: center; font-size: 1.2em;">Washington</p> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <p style="text-align: center; font-size: 1.2em;">Washington</p> d. STREET ADDRESS <p style="text-align: center; font-size: 1.2em;">624 - 3'd St., N.W.</p> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																											
<b>3. NAME OF DECEASED</b> (Type or print) <p style="text-align: center; font-size: 1.2em;">First Middle Last</p> <p style="text-align: center; font-size: 1.2em;">Frederick W. Bowers</p>		<b>4. DATE OF DEATH</b> <p style="text-align: center; font-size: 1.2em;">Month Day Year</p> <p style="text-align: center; font-size: 1.2em;">April 30 1961</p>		<b>5. SEX</b> <p style="text-align: center; font-size: 1.2em;">Male</p>		<b>6. COLOR OR RACE</b> <p style="text-align: center; font-size: 1.2em;">White</p>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <p style="text-align: center; font-size: 1.2em;">1/10/03</p>		<b>9. AGE</b> (In years last birthday) <p style="text-align: center; font-size: 1.2em;">58 yrs.</p>		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.																															
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <p style="text-align: center; font-size: 1.2em;">Hotel Clerk</p>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <p style="text-align: center; font-size: 1.2em;">Washington, D.C., Maryland</p>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <p style="text-align: center; font-size: 1.2em;">U.S.A.</p>																																			
<b>13. FATHER'S NAME</b> <p style="text-align: center; font-size: 1.2em;">Clarence Bowers</p>				<b>14. MOTHER'S MAIDEN NAME</b> <p style="text-align: center; font-size: 1.2em;">Josephine Gray</p>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) Yes <input checked="" type="checkbox"/> National Guard 579-03-8941				<b>16. SOCIAL SECURITY NO.</b> <p style="text-align: center; font-size: 1.2em;">1938-1941</p>				<b>17. INFORMANT</b> <p style="text-align: center; font-size: 1.2em;">Decedent</p>																															
<b>18. CAUSE OF DEATH</b> (Enter only one cause of death for (a), (b), and (c).) <table style="width: 100%;"> <tr> <td colspan="12" style="vertical-align: top;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <p style="text-align: center; font-size: 1.2em;">Carcinoma of the rectum with metastases</p> </td> <td colspan="4" style="vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <p style="text-align: center; font-size: 1.2em;">1 yr. 7 mo.</p> </td> </tr> <tr> <td colspan="12" style="vertical-align: top;"> <b>DUE TO</b>                  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  <b>DUE TO</b>                  (b)                  (c)             </td> <td colspan="4"></td> </tr> </table>																<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <p style="text-align: center; font-size: 1.2em;">Carcinoma of the rectum with metastases</p>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <p style="text-align: center; font-size: 1.2em;">1 yr. 7 mo.</p>				<b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>DUE TO</b> (b) (c)															
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <p style="text-align: center; font-size: 1.2em;">Carcinoma of the rectum with metastases</p>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <p style="text-align: center; font-size: 1.2em;">1 yr. 7 mo.</p>																																			
<b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>DUE TO</b> (b) (c)																																															
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <p style="text-align: center; font-size: 1.2em;">Abdominal-perineal resection and appendectomy 9/59; severe coronary artery atherosclerosis; pulm. tbc.; minimal, inactive; left orchidectomy 7/60</p>																																															
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																															
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																																											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <p style="text-align: center; font-size: 1.2em;">19</p>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> <p style="text-align: center; font-size: 1.2em;">Jan. 27, 1961 to April 30, 1961</p>																																			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <p style="text-align: center; font-size: 1.2em;">March 30, 1961</p> <b>and that death occurred at</b> <p style="text-align: center; font-size: 1.2em;">12:30 p.m.</p> <b>from the causes and on the date stated above.</b>																																															
<b>22a. SIGNATURE</b> <p style="text-align: center; font-size: 1.2em;">Moe Weiss</p>								<b>22b. DATE SIGNED</b> <p style="text-align: center; font-size: 1.2em;">4/30/61</p>				<b>22c. PHYSICIAN'S NAME (Type)</b> <p style="text-align: center; font-size: 1.2em;">Moe Weiss</p>																																			
<b>22d. ADDRESS</b> <p style="text-align: center; font-size: 1.2em;">Glenn Dale Hospital, Maryland</p>								<b>22e. MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22f. ADDRESS</b>																																			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <p style="text-align: center; font-size: 1.2em;">Burial</p>				<b>23b. DATE THEREOF</b> <p style="text-align: center; font-size: 1.2em;">May 5, 1961</p>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <p style="text-align: center; font-size: 1.2em;">Cedar Hill</p>				<b>23d. LOCATION</b> (City, town or county) (State) <p style="text-align: center; font-size: 1.2em;">Vp. Geo. Co., Md.</p>																																			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <p style="text-align: center; font-size: 1.2em;">M. W. Chambers Co. Inc. 1400 Chapin St. N.W. Washington D.C.</p>																																															
<b>25a. REC'D BY REGISTRAR</b> <p style="text-align: center; font-size: 1.2em;">DATE MAY 5 '61</p>								<b>25b. REGISTRAR'S SIGNATURE</b> <p style="text-align: center; font-size: 1.2em;">Arthur S. Thomas</p>																																							

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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Police Bureau

Office of the Chief

Chief of Police

Inspector

Patrol

Chief of Police

Chief of Police

Chief of Police

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Chief of Police

Chief of Police

Chief of Police

Chief of Police

Chief of Police

Chief of Police

Chief of Police

Chief of Police

4613

CERTIFICATE OF DEATH

Reg. Dist. No. 04607

1. PLACE OF DEATH o. COUNTY <b>Prince George County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Allentown</b>		c. LENGTH OF STAY IN 1b <b>20 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Allentown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6665 Pat's Lane, S. E.</b>				d. STREET ADDRESS <b>6665 Pat's Lane, S. E.</b>			
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Margaret</b> Last <b>Brandl</b>				4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1961</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 6, 1873</b>		9. AGE (In years last birthday) <b>88 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Koenigsberg, Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>Austria</b> ✓	
13. FATHER'S NAME <b>Josef Jager</b>				14. MOTHER'S MAIDEN NAME <b>Margareta Klieba</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Erica Brandl, 6665 Pat's Lane, S. E.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis (Right Hemiplegia)</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-Sclerosis - Senility</b> DUE TO <b>Diabetes Mellitus</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>10 yrs.</b> <b>3 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured Thoracic Vertebrae 1955</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>53</b> , to <b>4/5/61</b> , 19____, that I last saw the deceased alive on <b>3/31</b> , 19 <b>61</b> , and that death occurred at <b>9:42P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7519 Broadview Rd., S. E.</b> DATE SIGNED <b>4/5/61</b>							
ACTUAL SIGNATURE <b>Anna Coyne Todd</b> M.D.				DATE SIGNED <b>4/5/61</b>			
PHYSICIAN'S NAME (Type) <b>Anna Coyne Todd, M.D.</b>				Washington, 22, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/8/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Washington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Rd. Pr. Geo. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co., 517--11th St. S.E. Wash. DC</b>				24a. REC'D BY REGISTRAR DATE <b>APR 10 61</b>		24b. REGISTRAR'S SIGNATURE <b>Anna S. Todd</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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Page 4 of 5

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July 1961 August 1961

Free Special e-Newsletters CO PENDING N. J.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>6 Hr. 13 Min</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>6230 Lee Place</b> d. STREET ADDRESS <b>Cedar Heights</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy Brown</b>		4. DATE OF DEATH Month <b>Apr.</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 5, 1961</b>
9. AGE (In years last birthday) <b>6</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b>6</b> Min <b>13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Aaron Eugene Thorne</b>	
14. MOTHER'S MAIDEN NAME <b>Isabelle Ralph</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>None</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mother</b> Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>atelectasis</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Prematurely</b> (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Apr. 5, 1961</b> to <b>Apr. 5, 1961</b> , that (I) (we) last saw the deceased alive on <b>Apr. 5, 1961</b> at <b>11:30 P.</b> , and that death occurred at <b>11:30 P.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John Perkins</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Dr. John Perkins, M.D.</b>		22b. DATE SIGNED ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>5-12-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hospital</b>		23d. LOCATION (City, town or county) (State) <b>Cheverly, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr. Adm.</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 15 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

VR A15 (4)  
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				b. COUNTY			
Prince George				Maryland Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Cheverly		14 days		Seabrook		26	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Prince George General Hospital				9321 Worrel Ave.			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		Month Day Year	
First Middle Last				April 28		19 61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		White				October 15, 1887 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife,		Own home		Martinsburg, W. Va.		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Sakeman				Lucinda White			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT			
No,		None		Cumb. Md. Terrace, Mr. George E. Brown 451 N. Waverly			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Pulmonary Edema DUE TO Cerebral Thrombosis DUE TO Generalized arterio-sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from April 15, 1961 to April 28, 1961, that (I) (we) last saw the deceased alive on April 28, 1961, and that death occurred at 4:30 p.m. from the causes and on the date stated above. 22a. SIGNATURE [Signature] M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 4-28-61 22c. PHYSICIAN'S NAME (Type) W.C. ETIENNE 22d. ADDRESS College Park, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5/2/61 23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem. 23d. LOCATION (City, town or county) (State) Cumberland, Md. 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. Wayne George Cumberland, Md. 25a. REC'D BY REGISTRAR MAY 2 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Kenna							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04610

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital		d. STREET ADDRESS 13X-2	
3. NAME OF DECEASED (Type or print) First Scott Middle Francis Last Brown		4. DATE OF DEATH Month April Day 17 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1880
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Brown		14. MOTHER'S MAIDEN NAME Ella J. Dannel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-40-5728	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Hypertension C-V Dis. - 10 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Gen'l Arteriosclerosis 20 yrs (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchitis		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/30, 1937, to 4/19, 1961, that I last saw the deceased alive on 4/16/61, 19, and that death occurred at 6:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE J. M. Warren M.D.		Laurel 4/17/61	
PHYSICIAN'S NAME (Type) John M. Warren, M.D. 305 Prince George Street, Laurel, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	4/19/61	Emmanuel Cemetery	Scaggville Md
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
Clifford S. Randall, Laurel, Md		DATE APR 25 '61 Arthur S. Thomas	



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND										2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chapel Hill										c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) B Chapel Hill									
c. LENGTH OF STAY IN 1b 9 years										d. STREET ADDRESS 1 9228-Old Fort Road									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9228-Old Fort Road										a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Mary Elizabeth Browner										4. DATE OF DEATH April 29 1961									
5. SEX Female										6. COLOR OR RACE Colored									
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										8. DATE OF BIRTH Aug 25, 1940									
9. AGE (In years last birthday) 20 yrs.										IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker										10b. KIND OF BUSINESS OR INDUSTRY									
11. BIRTHPLACE (State or foreign country) Maryland										12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Bernard Browner										14. MOTHER'S MAIDEN NAME Marie Young									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No										16. SOCIAL SECURITY NO. (If yes give war or dates of service)									
17. INFORMANT Mr. Bernard Browner										Address 9228 Old Fort Rd, Chapel Hill									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) mine soil churning Brown body (c) DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of a house that burned									
20c. TIME OF INJURY Month, Day, Year 4:30 p.m. 4/29/1961										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home										20f. (City or town) Chapel Hill P.G. (County) ind (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE James I. Boyle										CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) JAMES I. Boyle										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
										DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
										Address (Street, city, town, or county) 4-29-61									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF MAY 2, 1961									
22c. NAME OF CEMETERY OR CREMATORY Church										22d. LOCATION (City, town, or county) (State) Chapel Hill, MD.									
23. FUNERAL DIRECTOR John T. Rhines Co. 3015-128t										24a. REC'D BY REGISTRAR DATE MAY 3 '61									
										24b. REGISTRAR'S SIGNATURE Wm. S. Rhines									

HE. WASHINGTON DC

10001

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10001

THIS IS TO CERTIFY THAT  
ON THE 10th DAY OF  
JANUARY 1901

(17)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 7 be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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04612

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1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>9400 Woodberry St</b>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth Buchanan</b>		4. DATE OF DEATH <b>April 30 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>"hite"</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/3/87</b>
9. AGE (in years last birthday) <b>73 yrs.</b>		10. AGE IF UNDER 1 YEAR Months <b>3</b> Days <b>30</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY <b>England</b>	
13. FATHER'S NAME <b>Roderick McDonald</b>		14. MOTHER'S MAIDEN NAME <b>Mary ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. John Buchanan</b>		Address <b>Same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>151X Cardiac mate 3x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Adeno Car. of the Stomach 9ms</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <b>3 ms.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 19 60</b> , to <b>4-30-19 61</b> , that (I) (we) last saw the deceased alive on <b>4-30-19 61</b> , and that death occurred at <b>8P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Albert J. Oehl</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/3/61</b>	
23c. NAME OF CEMETERY OR CREMATION <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 4 '61</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Pinner</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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4625  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
04613

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>77 College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Island Memorial Hospital</u>				d. STREET ADDRESS <u>1920 7-51<sup>st</sup> Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Teresa</u> Middle <u>Candamil</u> Last <u>Candamil</u>				4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 14 1908</u>	
9. AGE (In years lost birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Spain</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Eusebio Perez</u>				14. MOTHER'S MAIDEN NAME <u>Segunda Rodriguez</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Frank Candamil--9207 51st Avenue College Park, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage massive, pharynx &amp; right ear.</u> 142.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Partial Cerebral Catastrophe 3 yrs</u> DUE TO <u>Carcinoma of cerebellum, pharynx &amp; ear.</u> (c) <u>to cerebellum, pharynx &amp; ear.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or Town) <u>College Park</u> (County) <u>Prince George's</u> (State) <u>Md</u>							
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 8 1961</u> to <u>April 6 1961</u> that (I) (we) last saw the deceased alive on <u>4/8</u> , 19 <u>61</u> , and that death occurred at <u>4:00</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>W. L. Etienne</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>4-8-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>				22d. ADDRESS <u>College Park, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4/12/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. - Arlington, Virginia</u>		23d. LOCATION (City, town, or county) (State) <u>Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.</u> ADDRESS				25a. REC'D BY REGISTRAR <u>APR 11 1961</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Carlton S. Hines</u>	

CERTIFICATE OF DEATH

1922

M

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Place of birth  
6. Date of death  
7. Place of death  
8. Cause of death  
9. Signature of physician  
10. Signature of registrar  
11. Signature of coroner  
12. Signature of medical examiner  
13. Signature of health officer  
14. Signature of local health officer  
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100. Signature of local health officer

**1**  
**FOR STATE**  
**HEALTH DEPT.**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04614

1. PLACE OF DEATH a. COUNTY		Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		Maryland		b. COUNTY		Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?			
Cheverly		Dead on arrival		Upper Marlboro		None		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
Prince George's General Hospital		James		Lewellyn		Carroll		April		25th., 19 61	
3. NAME OF DECEASED (Type or print)		5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years fast birthday) yrs.	
		Male		Colored				January 12, 1886		75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Farmer - Laborer Ret.		State Roads of Md.		Knottingham, Maryland		USA.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Benjamin Carroll		Jane Crawford									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		None		Yes, Unknown Mrs. Sadie V. Burnett,		1824 S St., N.W.,					
						Washington, D. C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH					
442X		DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Cardiovascular Renal Disease							
		DUE TO									
		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		JAMES I. BOYD, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
						DATE SIGNED		April 25th., 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)					
Burial		4-29-61		Gibbons Church		Brandywine, Md.					
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Myrtle K. Rollins		4339 Hunt Pl., N.E., D.C.		APR 28 '61		Arthur S. Hines					

FOR SALE  
BENTON

(M)

(I)

DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1928

NAME: [illegible]  
SEX: [illegible]  
AGE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
OCCUPATION: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

## CERTIFICATE OF DEATH

Reg. Dist. No. 4627 44615

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>				c. LENGTH OF STAY IN 1b <u>1 year</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>57-HORSESHOE DR.</u>				d. STREET ADDRESS <u>57-HORSESHOE DR.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY KING CARTER</u>				4. DATE OF DEATH Month Day Year <u>April 17 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 24-1868</u>	
9. AGE (In years last birthday) <u>92 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN B. RICH</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>WILLIE M. CATINA Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 17, 1960</u> , to <u>April 17, 1961</u> , that I last saw the deceased alive on <u>April 17, 1961</u> , and that death occurred at <u>7:50 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David N. Robb</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>5116 Middleton Lane Washington 22 DC April 17 1961</u>			
PHYSICIAN'S NAME (Type) <u>DAVID N. ROBB</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial April 19-61</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Terrill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Terrill Oklahoma</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>				ADDRESS <u>1661 Good Hope Rd SE Washington 26 DC</u>		24a. REC'D BY REGISTRAR DATE <u>APR 19 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chilmer S. Travis</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
4628											
04616											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>						c. LENGTH OF STAY IN 1b <b>2 hrs</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Hilbourne Walter Chapman</b>						4. DATE OF DEATH <b>April 26 19 61</b>					
5. SEX <b>Male</b>						6. COLOR OR RACE <b>White</b>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <b>25 Jan 1916</b>					
9. AGE (In years last birthday) <b>45 yrs.</b>						10. IF UNDER 1 YEAR Months <b>4</b> Days <b>26</b> Hours <b>19</b> Min. <b>61</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Statistician</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>British Embassy</b>					
11. BIRTHPLACE (County & State, or foreign country) <b>London, England</b>						12. CITIZEN OF WHAT COUNTRY? <b>England</b>					
13. FATHER'S NAME <b>Theodore Chapman</b>						14. MOTHER'S MAIDEN NAME <b>Agnes Mason</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. (If yes, give number or date of service) <b>None</b>					
17. INFORMANT <b>Ella A. Chapman, 510--65th Ave., Wash. 27, D.C.</b>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Atherosclerosis of art.</b> 420.0 DUE TO <b>Ascending Branch of Left Coronary</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Edema</b>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>June 14, 1957</b> to <b>April 26, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 26, 1961</b> , and that death occurred <b>12.10 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>William Brainin</b> M.D.											
22b. DATE SIGNED <b>4/26/61</b>											
22c. PHYSICIAN'S NAME (Type) <b>Dr. William Brainin, M.D.</b>											
22d. ADDRESS <b>6124 Central Ave. Capitol Hgts, Md</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>											
23b. DATE THEREOF <b>4/29/1961</b>											
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>											
23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Pr. Geo. Co., Md.</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chapman &amp; Co</b> ADDRESS <b>Wash. DC.</b>											
25a. REC'D BY REGISTRAR <b>MAY 1 '61</b>											
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>											

00016

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(M)

(1)

Mr. J. Edgar Hoover, Director, FBI, Washington, D.C.

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above. The original of this memorandum is being furnished to the Department of Justice for its information.

Very truly yours,

Walter E. Rorer, Special Agent in Charge

Walter E. Rorer

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4629

## CERTIFICATE OF DEATH

Reg. Dist. No.

04617

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				c. LENGTH OF STAY IN TB <b>5 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>5706 30th Avenue</b>				d. STREET ADDRESS <b>5706 30th Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Rufus</b> Middle <b>Samuel</b> Last <b>Christy</b>				4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 8, 1905</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet metal worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Sheet metal</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Charleton Christy</b>				14. MOTHER'S MAIDEN NAME <b>Blanche UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>577-10-3687</b>		17. INFORMANT <b>Gertrude Viola Christy</b> <b>5706 30th Ave. Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary atherosclerosis</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>June 14, 1956</b> to <b>April 24</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>April 24</b> , 19 <b>61</b> , and that death occurred at <b>7:05 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6480 New Hampshire Avenue</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Norman H. Rubenstein</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Norman H. Rubenstein, M.D.</b>				Takoma Park, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-26-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>BLADENSBURG, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers &amp; Co. Ruridale, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 26 61</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Thrall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>4630</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>04618</div> </div> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Leland Memorial Hospital</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b> d. STREET ADDRESS <b>13 T, Hillside Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <b>Francis Reynolds Clark</b>					<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>22</b> Year <b>1961</b>				
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Sept. 10, 1911</b>		<b>9. AGE</b> (In years last birthday) <b>49</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Cab Driver</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Hacking</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>West Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Grant Clark</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Lenore Mac Donald</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Mrs Dorothy Clark, same as # 2</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cardiovascular renal disease</b> DUE TO (c)									<b>INTERVAL BETWEEN ONSET AND DEATH</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTORY <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <i>James I. Boyd</i>					<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>April 22, 1961</b>				
<b>EXAMINER'S NAME</b> (Type) <b>James I. Boyd, M.D.</b>					<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> Address (Street, city, town, or county)				
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>April 24, 1961</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Oakland</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Oakland Md</b>			
<b>23. FUNERAL DIRECTOR</b> ADDRESS <b>F. Gasch's Sons Hyattsville Md.</b>					<b>24a. REC'D BY REGISTRAR</b> DATE <b>APR 26 '61</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kincaid</i>		

YOU ARE  
HEALTHY

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James I. Boyd, M.D.

Special Agent in Charge, U.S. Bureau of Investigation

March 22, 1937

Dear Sir:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4631 Item 8 Film G285 4/26/61 jwk											
CERTIFICATE OF DEATH 04619											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN 1b 12 hrs					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital						e. STREET ADDRESS 221 Maryland Ave.					
3. NAME OF DECEASED (Type or print) Charles H Clawson						4. DATE OF DEATH 17 April 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 Sept. 1889		9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard-- Retired				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (County & State, or foreign country) Indiana County, Penna.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Clawson						14. MOTHER'S MAIDEN NAME Sarah Pitt					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Laura Ruth Hoofring, 221 Md. Ave. Parkland, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulated hernia, gangrenous bowel 561.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 4 days											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 4-16-61 to 4-17-61 that (I) (we) last saw the deceased alive on 4-17-61 and that death occurred at 2:30 AM from the causes and on the date stated above.											
22a. SIGNATURE Donald W. Mitchell M.D.											
22b. DATE SIGNED 4/17/61											
22c. PHYSICIAN'S NAME (Type) Dr. D. Mitchell, M.D.											
22d. ADDRESS Washington D.C.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 4/19/1961											
23c. NAME OF CEMETERY OR CREMATORY Spring Church Lutheran Cem.											
23d. LOCATION (City, town or county) (State) Spring Church, Penna.											
24. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO 517 11ST. SE.											
25a. REC'D BY REGISTRAR APR 24 '61											
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas											



TO HOSPITAL 4. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 (b) be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4632

## CERTIFICATE OF DEATH

04620

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>102 11th St. West</u>			
3. NAME OF DECEASED (Type or print) <u>Carlton W. Coburn</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>19 61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 24, 1957</u>	
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>John R. Coburn</u>				14. MOTHER'S MAIDEN NAME <u>Edna</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes give war or date of service) <u>  </u>				17. INFORMANT <u>John Coburn</u> Address <u>Bowie, Md</u>			
16. SOCIAL SECURITY NO. <u>  </u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Waterhouse-Freidrickson Syndrome</u> <u>057.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Meningococcemia (Neisseria intracellularis)</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH hours <u>  </u> hours <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 22</u> , 19 <u>61</u> , to <u>April 22</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>April 22</u> , 19 <u>61</u> , and that death occurred at <u>10:45 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John W Perkins</u> M.D.				22b. DATE SIGNED <u>  </u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. John W Perkins, M.D.</u>				22d. ADDRESS <u>5301 Hamilton St., Hyattsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 24-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Guschi Sons</u> ADDRESS <u>Hyattsville Md</u>				25a. REC'D BY REGISTRAR <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>APR 26 '61</u>							

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Truman George General Hospital

Section 1

John P. Coburn

Washington-Portland Highway

Washington-Portland Highway

April 28, 1941

April 28, 1941

2501 Madison St.  
Hawthorne, La.

W. John L. L. L.

April 28, 1941

Handwritten signature and text at the bottom right of the page.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
4633 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04621

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN IB <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>139 Archwood Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Thomas James Cole Jr.</b>		4. DATE OF DEATH <b>April 9, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 4, 1906</b>
9. AGE (In years last birthday) <b>55 yrs.</b>		IF UNDER 1 YEAR Months Days <b>9 19 61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Gas and Elec. Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas James Cole Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Josephine Quinn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Margaret W. Cole, same as # 2</b>	
17. INFORMANT <b>Margaret W. Cole, same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER NAME (Type) <b>James I. Boyd</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>12 Rural</b>		22b. DATE THEREOF <b>4-12-1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Marys Cem</b>		22d. LOCATION (City, town, or country) (State) <b>Annapolis Md</b>	
23. FUNERAL DIRECTOR <b>Joem M. Layton Sons</b>		24a. REC'D BY REGISTRAR <b>APR 12 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE	

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*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4634 CERTIFICATE OF DEATH 04622											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 41 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Park				d. STREET ADDRESS 406 65th Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) James D Comer						4. DATE OF DEATH April 30 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 Dec. 1893		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing pressman				10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (County & State, or foreign country) New Jersey				12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Daniel Comer						14. MOTHER'S MAIDEN NAME Elizabeth A. Rafferty					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16. SOCIAL SECURITY NO. 141 03 1737		17. INFORMANT Address Esther M Comer Maryland Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 585X HEPATIC & UREMIC COMA (FAILURE) DUE TO (b) ACUTE LIVER - ATROPHY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) CHOLANGITIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Seat Pleasant, Md.		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 3-20 1961, to 4-30 1961, that (I) (we) last saw the deceased alive on 4-29 1961, and that death occurred at 5:10 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Max M. Herzberg M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-30-61			
22c. PHYSICIAN'S NAME (Type) Dr. Max M Herzberg ., M.D.						22d. ADDRESS 7016 Greigg Street Seat Pleasant., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 3, 1961		23c. NAME OF CEMETERY OR <del>XXXXXX</del> Arlington National		23d. LOCATION (City, town or county) Arlington Virginia		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR MAY 3 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kram			

VR A15 (4)  
15M 9/60

11/15/54

11/15/54

(M)

(1)

111 03 1957 Rachel A Comer, Maryland Park, Md.  
Elizabeth A. Salter

HEART - 2 WOUNDS - 1 (F) - 1 (G)  
ACT - 1 WOUND - 1 (F) - 1 (G)  
CHANDLER

Washington Virginia

May 3, 1961 Arlington National

W. Mason's home Hyattsville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4635

04623

1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 28 Days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Harry H. Cooper				4. DATE OF DEATH Month Day Year April 3 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/25/04	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Contractor				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William N. Cooper				14. MOTHER'S MAIDEN NAME Arminia Saunders			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 214 12 7871				16. SOCIAL SECURITY NO. 214 12 7871			
17. INFORMANT Bonnie M. Cooper				Address 13 Duvall St, Suitland Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200.1 Lymphosarcoma - generalized DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 mos.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Sept 9, 1960, to April 3, 1961, that (I) (we) last saw the deceased alive on April 3, 1961, and that death occurred at 9:50 PM from the causes and on the date stated above.							
22a. SIGNATURE Harry N. Carlton, M.D.				22b. DATE Apr 4, 61			
22c. PHYSICIAN'S NAME (Type) Harry N. Carlton				22d. ADDRESS 940 25th St., N. W. Wash. DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 6, 1961		23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l		23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Summers Bros 1661 Woodbury Rd				25a. REC'D BY REGISTRAR APR 6 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

(M)

1933

STATE OF TEXAS

1933

County of \_\_\_\_\_ State of Texas

Know all men by these presents, that \_\_\_\_\_ of the County of \_\_\_\_\_ State of Texas

do hereby certify that \_\_\_\_\_ of the County of \_\_\_\_\_ State of Texas

is the owner of the following described land, to-wit:

\_\_\_\_\_

and that the same is subject to the following described lien, to-wit:

\_\_\_\_\_

and that the same is subject to the following described lien, to-wit:

\_\_\_\_\_

and that the same is subject to the following described lien, to-wit:

\_\_\_\_\_

and that the same is subject to the following described lien, to-wit:

\_\_\_\_\_

and that the same is subject to the following described lien, to-wit:

\_\_\_\_\_

and that the same is subject to the following described lien, to-wit:

\_\_\_\_\_

and that the same is subject to the following described lien, to-wit:

\_\_\_\_\_

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>	
c. LENGTH OF STAY IN 1b <b>50 Years</b>		d. STREET ADDRESS <b>5421 Lanham Station Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5421 Lanham Station Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth Cunningham Corridon</b>		4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 22, 1879</b>
9. AGE (In years last birthday) <b>81 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Carey Cunningham</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bentley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>166-42-361</b>	
17. INFORMANT <b>Hugh B. Meloy Washington, D.C.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive heart failure</b> 442X DUE TO (b) <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTORY <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>4/24/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or country) (State) <b>Pr. Geo. Co. Md.</b>	
23. FUNERAL DIRECTOR <b>W. W. Chambers Co.</b>		24. REGISTRAR'S SIGNATURE <b>Arthur S. Fraser</b>	
ADDRESS <b>5801 Cleveland Ave. Riverdale, Md.</b>		DATE <b>APR 25 '61</b>	

MEDICAL CERTIFICATION

4-23-61

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1933

James George

Marion

TO BE FILLED BY THE

DEATH

1933

James

20 years

Marion

241 Madison Street, St. Paul

241 Madison Street, St. Paul

April

Corbin

Livingston

Elizabeth

September 12, 1933

James White

U. S. A.

Marion

Marion

Marion

Marion

Marion

3001 Madison Street

1414 B. Mary Washington, D.C.

To

1

VS. A15ME  
5M 7/59

04625

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		b. COUNTY <b>Prince George's</b>	
c. LENGTH OF STAY IN IB <b>Transient</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Birch Field</b>		d. STREET ADDRESS <b>9723 Wichita Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Robert Charles Cote</b>		4. DATE OF DEATH <b>April 3, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1949</b>
9. AGE (In years last birthday) <b>11</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	
12. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		13. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
14. FATHER'S NAME <b>Gerard Wilfred Cote</b>		15. MOTHER'S MAIDEN NAME <b>Hazel Byers</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>None</b>	
18. INFORMANT <b>Gerard W. Cote, same as # 2</b>		19. ADDRESS <b>College Park, Md.</b>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> Conditions, if any, which gave rise to immediate cause (b) <b>Hanging by neck</b> (c) <b>Asphyxia</b>		21. INTERVAL BETWEEN ONSET AND DEATH <b>936.8</b>	
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Was in a tree and tried to let himself down with a rope</b>		23. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
24. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>and got caught</b>		25. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was in a tree and tried to let himself down with a rope</b>	
26. TIME OF INJURY Month, Day, Year <b>3:30 p.m. 4/3/61</b>		27. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
28. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Wooded area</b>		29. (City or town) (County) (State) <b>College Park P. G. Md.</b>	
30. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		31. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
32. ACTUAL SIGNATURE <b>James I. Boyd</b>		33. DATE SIGNED <b>April 3, 1961</b>	
34. EXAMINER'S NAME (Type) <b>James I. Boyd</b>		35. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
36. ADDRESS (Street, city, town, or county) <b>3801 Cleveland Ave</b>		37. ADDRESS (Street, city, town, or county) <b>3801 Cleveland Ave</b>	
38. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		39. DATE THEREOF <b>4-7-61</b>	
40. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATL</b>		41. LOCATION (City, town, or country) (State) <b>FT MYER VA</b>	
42. FUNERAL DIRECTOR <b>W.W. Chambers</b>		43. REC'D BY REGISTRAR <b>APR 6 '61</b>	
44. REGISTRAR'S SIGNATURE <b>W.W. Chambers</b>		45. REGISTRAR'S SIGNATURE <b>W.W. Chambers</b>	

STATE  
DEPT



RECEIVED  
JAN 10 1901

MASSACHUSETTS DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
No. 1234  
Name: John Doe  
Age: 45  
Sex: Male  
Race: White  
Birth: Jan 1, 1856  
Place of Birth: Boston, Mass.  
Education: High School  
Occupation: Carpenter  
Cause of Death: Heart Disease  
Date of Death: Dec 15, 1900  
Place of Death: Home  
Buried: Yes  
Burial Place: Mount Hope Cemetery  
Signature: [Signature]  
Date: Dec 20, 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04626

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UPPER MARLBORO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES HOSPITAL</u>		d. STREET ADDRESS <u>1 R.F.D. BOX 2372</u>	
3. NAME OF DECEASED (Type or print) <u>Charlotte A Curtin</u>		4. DATE OF DEATH <u>Apr 27 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-02</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HERBERT B. HARRIS</u>		14. MOTHER'S MAIDEN NAME <u>MABLE C. FERGUSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-05-2599</u>	
17. INFORMANT <u>MILDRED CURTIN</u>		Address <u>UPPER MARLBORO, R.F.D. BOX 2374</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>7 AM</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 27</u> , 19 <u>61</u> , to <u>Apr 27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>27 Apr</u> , 19 <u>61</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. B. Janner</u>		DATE SIGNED <u>4-27-61</u>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-2-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>		24a. REC'D BY REGISTRAR <u>Wash. DC</u>	
ADDRESS <u>3821-14th St. N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kross</u>	
DATE <u>1 '61</u>			



## CERTIFICATE OF DEATH

Reg. Dist. No. 04627

4630

1. PLACE OF DEATH o. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lenham				c. LENGTH OF STAY IN 1b 36 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6117 Princess Garden Parkway				d. STREET ADDRESS 6117 Princess Garden Parkway			
3. NAME OF DECEASED (Type or print) First Middle Last Walter Edmund Donn				4. DATE OF DEATH Month Day Year April 11 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 24, 1895	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER				10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frank Donn				14. MOTHER'S MAIDEN NAME Catherine Monahan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1918-1919				16. SOCIAL SECURITY NO. 1918-1919			
17. INFORMATION Mrs. Hilda Wiser, 6117 Princess Garden Parkway,				Address Lanham, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO (c) Arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH few hours 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan 1961, to April 1961, that I last saw the deceased alive on 4/10/1961, and that death occurred at 8 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7732 Annapolis Rd, Lanham, Md							
ACTUAL SIGNATURE HEI K. LEE				PHYSICIAN'S NAME (Type) HEI K. LEE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 14, 1961		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.,				ADDRESS Riverdale, Maryland.		24a. REC'D BY REGISTRAR DATE APR 14 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12/5/28		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 175	
11. CAUSE OF DEATH Myocardial Infarction		12. MANNER OF DEATH Natural		13. DATE OF DEATH 6/8/64		14. PLACE OF DEATH Baltimore, Md.		15. SIGNATURE OF PHYSICIAN [Signature]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF DECEASED [Signature]		19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF DECEASED [Signature]	
21. SIGNATURE OF DECEASED [Signature]		22. SIGNATURE OF WITNESS [Signature]		23. SIGNATURE OF DECEASED [Signature]		24. SIGNATURE OF WITNESS [Signature]		25. SIGNATURE OF DECEASED [Signature]	
26. SIGNATURE OF DECEASED [Signature]		27. SIGNATURE OF WITNESS [Signature]		28. SIGNATURE OF DECEASED [Signature]		29. SIGNATURE OF WITNESS [Signature]		30. SIGNATURE OF DECEASED [Signature]	
31. SIGNATURE OF DECEASED [Signature]		32. SIGNATURE OF WITNESS [Signature]		33. SIGNATURE OF DECEASED [Signature]		34. SIGNATURE OF WITNESS [Signature]		35. SIGNATURE OF DECEASED [Signature]	
36. SIGNATURE OF DECEASED [Signature]		37. SIGNATURE OF WITNESS [Signature]		38. SIGNATURE OF DECEASED [Signature]		39. SIGNATURE OF WITNESS [Signature]		40. SIGNATURE OF DECEASED [Signature]	
41. SIGNATURE OF DECEASED [Signature]		42. SIGNATURE OF WITNESS [Signature]		43. SIGNATURE OF DECEASED [Signature]		44. SIGNATURE OF WITNESS [Signature]		45. SIGNATURE OF DECEASED [Signature]	
46. SIGNATURE OF DECEASED [Signature]		47. SIGNATURE OF WITNESS [Signature]		48. SIGNATURE OF DECEASED [Signature]		49. SIGNATURE OF WITNESS [Signature]		50. SIGNATURE OF DECEASED [Signature]	
51. SIGNATURE OF DECEASED [Signature]		52. SIGNATURE OF WITNESS [Signature]		53. SIGNATURE OF DECEASED [Signature]		54. SIGNATURE OF WITNESS [Signature]		55. SIGNATURE OF DECEASED [Signature]	
56. SIGNATURE OF DECEASED [Signature]		57. SIGNATURE OF WITNESS [Signature]		58. SIGNATURE OF DECEASED [Signature]		59. SIGNATURE OF WITNESS [Signature]		60. SIGNATURE OF DECEASED [Signature]	
61. SIGNATURE OF DECEASED [Signature]		62. SIGNATURE OF WITNESS [Signature]		63. SIGNATURE OF DECEASED [Signature]		64. SIGNATURE OF WITNESS [Signature]		65. SIGNATURE OF DECEASED [Signature]	
66. SIGNATURE OF DECEASED [Signature]		67. SIGNATURE OF WITNESS [Signature]		68. SIGNATURE OF DECEASED [Signature]		69. SIGNATURE OF WITNESS [Signature]		70. SIGNATURE OF DECEASED [Signature]	
71. SIGNATURE OF DECEASED [Signature]		72. SIGNATURE OF WITNESS [Signature]		73. SIGNATURE OF DECEASED [Signature]		74. SIGNATURE OF WITNESS [Signature]		75. SIGNATURE OF DECEASED [Signature]	
76. SIGNATURE OF DECEASED [Signature]		77. SIGNATURE OF WITNESS [Signature]		78. SIGNATURE OF DECEASED [Signature]		79. SIGNATURE OF WITNESS [Signature]		80. SIGNATURE OF DECEASED [Signature]	
81. SIGNATURE OF DECEASED [Signature]		82. SIGNATURE OF WITNESS [Signature]		83. SIGNATURE OF DECEASED [Signature]		84. SIGNATURE OF WITNESS [Signature]		85. SIGNATURE OF DECEASED [Signature]	
86. SIGNATURE OF DECEASED [Signature]		87. SIGNATURE OF WITNESS [Signature]		88. SIGNATURE OF DECEASED [Signature]		89. SIGNATURE OF WITNESS [Signature]		90. SIGNATURE OF DECEASED [Signature]	
91. SIGNATURE OF DECEASED [Signature]		92. SIGNATURE OF WITNESS [Signature]		93. SIGNATURE OF DECEASED [Signature]		94. SIGNATURE OF WITNESS [Signature]		95. SIGNATURE OF DECEASED [Signature]	
96. SIGNATURE OF DECEASED [Signature]		97. SIGNATURE OF WITNESS [Signature]		98. SIGNATURE OF DECEASED [Signature]		99. SIGNATURE OF WITNESS [Signature]		100. SIGNATURE OF DECEASED [Signature]	

RECEIVED  
JAN 10 1965  
BALTIMORE, MD

## CERTIFICATE OF DEATH

Reg. Dist. No. 04628

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 1 hr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7105 Riggs Rd. (Office of Dr. R.B. Irey)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
3. NAME OF DECEASED (Type or print) First Middle Last Frank Thomas Donnelly		4. DATE OF DEATH April 3 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1880
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steward -Dinning Car		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1	
17. INFORMANT Mrs. Nan Donnelly		Address 2700 30th St. N.E. Wash. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO (b) CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Arteriosclerosis DUE TO (c) 10 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure			INTERVAL BETWEEN ONSET AND DEATH IMMED " 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 1953, to April 1961, that I last saw the deceased alive on April 3, 1961, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7105 Riggs Rd. 4-3-61			
ACTUAL SIGNATURE Robert B. Irey		M.D. 7105 Riggs Rd.	
PHYSICIAN'S NAME (Type) ROBERT B. IREY		Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr 6, 1961	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Prince Georges, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Vincent		ADDRESS 2525 Bladensburg Rd N.E. Wash D.C.	
24a. REC'D BY REGISTRAR DATE APR 7 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
464: CERTIFICATE OF DEATH 04629

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>3 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>404105 51st. Street</b> d. STREET ADDRESS <b>1 Bladensburg</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edgar Dorsch</b>		4. DATE OF DEATH Month Day Year <b>April 25 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-15-91</b>
9. AGE (In years last birthday) <b>69</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>	
17. INFORMANT <b>Cornelia B. Dorsch</b>		Address <b>4105 51st St. Bladensburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis Ht disease</b> DUE TO (c) <b>athromatous avel Left Cor. Art.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 23 1961</b> , to <b>April 25 1961</b> , that (I) (we) last saw the deceased alive on <b>April 25 1961</b> , and that death occurred at <b>7:20 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>B. Rosenberg</b>		22b. DATE SIGNED <b>April 26, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Rosenberg, M.D.</b>		22d. ADDRESS <b>5102 Annapolis Road, Bladensburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 28, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. Riverdale, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

# STATE OF DEATH

(M)

(L)

April 22, 1932

5102 Franklin Road, Richmond, Va.

Dr. J. H. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4642

04630

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 28 days		d. STREET ADDRESS 2025 8th St., N. W.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Leander - Douglas		4. DATE OF DEATH Month Day Year 4 7 19 61	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/1891
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY McGhan Scaffold Company	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mark Douglas		14. MOTHER'S MAIDEN NAME Cormora Douglas (Byrd)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown (lost)	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 17 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, moderately advanced, active (5 months); right tuberculous pleurisy with effusion; generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/10 5:10 PM to 4/7 4:45 PM, 19 61 that (I) (we) last saw the deceased alive on 4/7 19 61, and that death occurred at 4:45 PM, from the causes and on the date stated above.			
22a. SIGNATURE William J. Washington Jr. M.D.		22b. DATE SIGNED 4/7/1961	
22c. PHYSICIAN'S NAME (Type) William J. Washington, Jr., M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-11-1961	
23c. NAME OF CEMETERY OR CREMATORY Harmony		23d. LOCATION (City, town or county) Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Johnson & Jenkins		25a. REC'D BY REGISTRAR APR 10 '61	
ADDRESS 4804 Centre Ave. N.W.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



William H. H. H.

11-11-11  
1881

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4643

04631

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u> c. LENGTH OF STAY IN 1b <u>9 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2708-Fairlawn St.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u> d. STREET ADDRESS <u>2708-Fairlawn St.</u> RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
<b>3. NAME OF DECEASED</b> (Type or print) <u>ADA</u> First <u>MARY</u> Middle <u>EDWARDS</u> Last		<b>4. DATE OF DEATH</b> <u>April 1</u> Month <u>1961</u> Year		<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>JULY 10 1972</u>		<b>9. AGE</b> (In years last birthday) <u>88</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>NC</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>											
<b>13. FATHER'S NAME</b> <u>WILLIAM W NOLAN</u>								<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY ANN HOLLAND</u>															
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>None</u> (If yes give war or dates of service)								<b>16. SOCIAL SECURITY NO.</b> <u>None</u>								<b>17. INFORMANT</b> <u>Eunice E. Morrison</u> Address <u>  </u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO (b) <u>MULTIPLE METASTASE of CARCINOMA</u> DUE TO (c) <u>CARCINOMATOSIS-PRIMARY OF FACE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																INTERVAL BETWEEN ONSET AND DEATH <u>3-DAYS</u> <u>3 YRS.</u> <u>6 YRS.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)											
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>19 SEPT 54</u> to <u>APRIL 1</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>MARCH 30 1961</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.																							
<b>22a. SIGNATURE</b> <u>Adney W. Lowry</u> M.D.								<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>4/1/61</u>											
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>S. W. LOWRY</u>								<b>22d. ADDRESS</b> <u>7200 MARLBORO PIKE SE WASH. 28 DC</u>															
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>4-5-61</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Springch. Cem</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Cataula N.C.</u>											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lee Funeral Home</u>								<b>25a. REC'D BY REGISTRAR</b> <u>4-6-61</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles E. Kneass</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)



Private George  
William White  
2708 - 2nd St.

EDWARDS  
April 1

ADA  
Female White

U.S.A.  
MARY ANN HOLLAND  
N.C.  
Service & Mission.

House Wife  
WILLIAM W. HOLLAN  
N.C.

the first of the year of the month of  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04632											
4644 Items 13 & 14 Film 9288 6/16/61 mh											
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarden 35					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital						d. STREET ADDRESS 7th Street					
3. NAME OF DECEASED (Type or print) First Middle Last Hubbard Eldridge						4. DATE OF DEATH Month Day Year Apr. 17 19 61					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 7, 1870		9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY South Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Marsie Eldridge						14. MOTHER'S MAIDEN NAME Judie					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Minnie Tillman, 7th St., Glenarden, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arterio Sclerosis (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2-18, 1937 to 4-17, 1961, that (I) (we) last saw the deceased alive on 4-15, 1961, and that death occurred at 3:05 A.M. the causes and on the date stated above.											
22a. SIGNATURE H. B. Beldon M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) H. B. Beldon M.D.						22d. ADDRESS 4423 Hunt Pl. NE DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF Apr. 21, 1961		23c. NAME OF CEMETERY OR CREMATORY Shipped to Anderson, S. C.		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE MALVAN & SCHEY, INC. 424 "R" St., N. W.						ADDRESS Wash., D. C.		25a. REC'D BY REGISTRAR APR 21 '61		25b. REGISTRAR'S SIGNATURE Cuthbert S. Hume	

(M)

(I)

REMOVED  
APR. 27, 1947 Shipped to Anderson, S. C.  
WASH. D. C.  
MALDEN & SORBY, INC. 424 "H" St., N. W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04633

4645

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>			
c. LENGTH OF STAY IN 1b <b>24 days</b>				d. STREET ADDRESS <b>3606 Bunker Hill Road</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>Pearl</b> Last <b>Fabritz</b>				4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 27, 1898</b>	
9. AGE (In years lost birthday) <b>63</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Department store clerk</b>			
13. FATHER'S NAME <b>Oliver Underwood</b>				14. MOTHER'S MAIDEN NAME <b>Annie Gibson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>579 28 1131</b>			
17. INFORMANT <b>Eugene L Fabritz</b>				Address <b>Mt. Rainier, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Supra cerebral hem. left</b> <b>204.4</b> DUE TO <b>hemiparesis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
INTERVAL BETWEEN ONSET AND DEATH <b>(day) 4 years</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1956 Ave.</b>	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <b>March 23, 1961</b> to <b>April 15, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 15, 1961</b> , and that death occurred at <b>5:00 P.M.</b> on the causes and on the date stated above.							
22a. SIGNATURE <b>Leon Levitsky</b>				22b. ADDRESS <b>3406 Rhodes Island Ave. Mt. Rainier, Md.</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Leon Levitsky M.D.</b>				22d. ADDRESS <b>3406 Rhodes Island Ave. Mt. Rainier, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 19, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 19 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

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*[Faint, illegible text]*

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4646

## CERTIFICATE OF DEATH

Reg. Dist. No.

04634

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 2108 Queens Chapel Rd.	
3. NAME OF DECEASED (Type or print) Carl B. Jones		4. DATE OF DEATH 4-30-1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH place date nov-14, 1905
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor, Ottoberg Bakery		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Randolph Jones		14. MOTHER'S MAIDEN NAME Evelyn Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 57707-2892	
17. INFORMANT Nevis H. Jones, Wife		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease (c) INTERVAL BETWEEN ONSET AND DEATH 15 minutes 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956, 19 to April, 1961, that I last saw the deceased alive on 4/27, 1961, and that death occurred at 2:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		DATE SIGNED 5/1/61	
PHYSICIAN'S NAME (Type) Hugh W. Irey		M.D. 7105 - Ridge Rd.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/3/61	
22c. NAME OF CEMETERY OR CREMATORY Benlah Baptist Cem.		22d. LOCATION (City, town, or county) (State) Warsaw, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		24a. REC'D BY REGISTRAR DATE MAY 4 '61	
ADDRESS Mt. Rainier Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11

1

I, James H. Jones, of the County of Franklin, State of Ohio, do hereby certify that James H. Jones, of the County of Franklin, State of Ohio, died on the 10th day of April, 1917, at 10:30 o'clock P.M., at the residence of the deceased, Franklin, Ohio, of the disease of Heart Disease, after a illness of 10 days.

The above is a true and correct copy of the original certificate of death filed in the office of the Registrar of Deaths, County of Franklin, State of Ohio, on the 10th day of April, 1917, at 10:30 o'clock P.M., at the residence of the deceased, Franklin, Ohio, of the disease of Heart Disease, after a illness of 10 days.

Witness my hand and seal of office this 10th day of April, 1917, at Franklin, Ohio.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 22c & d, Film G284 4/13/61 iwk

## CERTIFICATE OF DEATH

Reg. Dist. No. 04635

4647

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Pr George</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Pr George.</u></span>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marlow Heights.</u> <span style="float: right;"><u>18</u></span>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suitland Nursing Home.</u>				d. STREET ADDRESS <u>6017 - 28th Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Henry</u> Middle <u>M</u> Last <u>Frame</u>				<b>4. DATE OF DEATH</b> <u>April 1st. 1961.</u> <span style="float: right;">Month Day Year</span>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10-6-81</u>	<b>9. AGE</b> (In years lost birthday) <u>79</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b> Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>CRetired</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Cabinet Maker</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Mrs Anna Marie Frame - sam as above</u> <span style="float: right;">Address</span>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY INSUFFICIENCY</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>ATHEROSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>CARDIAC ARRHYTHMIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify</b> that I attended the deceased from <u>3/11</u> , 19 <u>61</u> , to <u>4/1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>MARCH 30</u> , 19 <u>61</u> , and that death occurred at <u>4/1/61 1:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4833 ST. BARNABAS RD</u> DATE SIGNED <u>4/1/61</u> ACTUAL SIGNATURE <u>Bruno Kolega</u> M.D. PHYSICIAN'S NAME (Type) <u>BRUNO KOLEGA</u> <u>WASHINGTON 21-DC. - Md.</u>								
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>4-5-61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>7th Myer Rd. Suitland, Md.</u>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lee Funeral Home Washington D.C.</u> <span style="float: right;">ADDRESS</span>				<b>24a. REC'D BY REGISTRAR</b> <u>APR 6 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Frame</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. O FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<b>1. PLACE OF DEATH</b> e. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>										<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1113</u>										c. LENGTH OF STAY IN 1b <u>DOA</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dobson Clinic</u>										d. STREET ADDRESS <u>1 Conti #1</u>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>James</u> First <u>J</u> Middle <u>G</u> Last <u>G</u>										<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>28</u> Year <u>1961</u>									
<b>5. SEX</b> <u>male</u>										<b>6. COLOR OR RACE</b> <u>White</u>									
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										<b>8. DATE OF BIRTH</b> <u>1882</u>									
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>laborer</u>										<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>farm</u>									
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>										<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>									
<b>13. FATHER'S NAME</b> <u>James Gerner</u>										<b>14. MOTHER'S MAIDEN NAME</b> <u>May Fowler</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>										<b>16. SOCIAL SECURITY NO.</b> <u>442X</u>									
<b>17. INFORMANT</b> <u>Walter Fowler, Aquasco, Md.</u> Address <u>Walter Fowler, Aquasco, Md.</u>										<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c), stating the underlying cause last. <u>Cardiovascular renal disease</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>										<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>										<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)										<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u> M.D.										<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>									
<b>EXAMINER'S NAME</b> (Type) <u>James I. Boyd</u>										<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>April 28, 1961</u>									
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>										<b>22b. DATE THEREOF</b> <u>Apr. 29/61</u>									
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Philips</u>										<b>22d. LOCATION</b> (City, town, or country) (State) <u>Aquasco, Md.</u>									
<b>23. FUNERAL DIRECTOR</b> <u>George G. Kelam</u> ADDRESS <u>Aquasco, Md.</u>										<b>24a. REC'D BY REGISTRAR</b> <u>MAH 2 '61</u>									
										<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kiana</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
Information from birth cert.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 4 hrs. 5 mins. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deanwood Park d. STREET ADDRESS 1003 54th Ave.											
3. NAME OF DECEASED (Type or print) Maurice Gillums		4. DATE OF DEATH April 14 19 61		5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 14, 1960		9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Prince George, Md.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Oscar Gresham				14. MOTHER'S MAIDEN NAME Jessie Lee Gillums											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } E lectro lyte infal. Dehydration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bladensburg, Md.		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from April 14, 19 61 to April 14, 19 61 that (I) (we) last saw the deceased alive on April 14, 19 61, and that death occurred at 3:30 p.m. from the causes and on the date stated above.															
22a. SIGNATURE John W. Perkins 22c. PHYSICIAN'S NAME (Type) John W. Perkins										M.D. 22d. ADDRESS Bladensburg, Md.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial				23b. DATE THEREOF 5/13/61		23c. NAME OF CEMETERY OR CREMATORY NAT. HARMONY CEM.				23d. LOCATION (City, town or county) (State) Prince Georges Co Md					
24. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines Co										ADDRESS 3015 12th St. N.E. DC		25a. REC'D BY REGISTRAR MAY 16 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

*[Faint handwritten notes at the bottom of the page, likely bleed-through from the reverse side.]*

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. LENGTH OF STAY IN lb 1 Week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hill crest Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				d. STREET ADDRESS 2406 Kenton Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		First Middle Last Grim		4. DATE OF DEATH April 26th		Day Year 1961	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15th 1877	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U. A. A.							
13. FATHER'S NAME Schwarz				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT John E. Grim 3800 Nellie Custis Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conjestive Heart Failure DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1958, to April 26, 1961, that (I) (we) last saw the deceased alive on April 26, 1961 and that death occurred at 9 A. M. from the causes and on the date stated above.							
22a. SIGNATURE J. H. Thibadeau				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-26-1961	
22c. PHYSICIAN'S NAME (Type) Joseph H. Thibadeau				22d. ADDRESS 3112 Alabama Ave S.E. Wash, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-28-1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Fort Myer, Va	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly				ADDRESS 131-11 St E Wash DC		25a. REC'D BY REGISTRAR DATE MAY 1 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 ( ) be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
4651 Items 11, 13 & 14 Film G285 4/24/61 14638											
1. PLACE OF DEATH e. COUNTY <b>PRINCE GEORGES MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <b>VIRGINIA</b> b. COUNTY <b>ARLINGTON</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS MD.</b>				c. LENGTH OF STAY IN 1b <b>12 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FALLS CHURCH</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>				d. STREET ADDRESS <b>420 Brook Dr</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Guenther, Leonore E</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>14</b> Year <b>1961</b>							
5. SEX <b>F</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>14</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Elkins</b>				14. MOTHER'S MAIDEN NAME <b>Leonora McSweeney</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Louis Guenther 420 Brook Dr. FALLS CH</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>INTRACRANIAL HEMORRHAGE</b> 204-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACUTE MONOCYTIC LEUKEMIA</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1960</b> to <b>APRIL 1961</b> , that (I) (we) last saw the deceased alive on <b>14 APRIL 1961</b> , and that death occurred at <b>5:40 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Andrew W. Buttrick</b>				22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type)			
22d. ADDRESS				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22f. PHYSICIAN'S NAME (Type)				22g. ADDRESS							
22h. BURIAL, CREMATION, REMOVAL (Specify)				22i. DATE THEREOF <b>April 18, 1961</b>				22j. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl</b>			
22k. LOCATION (City, town or county) (State) <b>Arlington Va</b>				22l. REC'D BY REGISTRAR				22m. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			
22n. FUNERAL DIRECTOR'S SIGNATURE <b>S. A. Murphy</b>				22o. ADDRESS <b>Arlington Va</b>				22p. DATE <b>APR 18 '61</b>			



24B. REGISTRAR'S SIGNATURE

FOR SIGNATURE  
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>15 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>Lanham P.O.</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>P amela</b> Middle <b>Patricia</b> Last <b>Hall</b>				<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>11</b> Year <b>19 61</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Black</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>X</b> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>28 Mar 1961</b>	
<b>9. AGE</b> (in years last birthday) <b>15 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>15</b> Days <b>15</b>		<b>IF UNDER 24 HRS.</b> Hours <b>15</b> Min. <b>15</b>		<b>10e. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Rudolph Hall Jr.</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Thersea Hutton</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Mother</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Oblectasi</b> <b>Pneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH  			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Enteritis, Dehydration</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour <b>a.m.</b> <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Mar. 28</b>		<b>20f. (City or town)</b> <b>61</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>19. 61</b> <b>to</b> <b>Apr. 11</b> , 19.61 <b>that (I) (we) last saw the deceased alive on</b> <b>Apr. 10</b> , 19.61, <b>and that death occurred at</b> <b>7.30AM</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>John W Perkins</b>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>X</b>		<b>22b. DATE SIGNED</b> <b>Apr. 11-61</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. John Perkins M.D.</b>				<b>22d. ADDRESS</b> <b>5301 Hamilton St., Hyattsville, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Cremation</b>		<b>23b. DATE THEREOF</b> <b>4/17/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Pr Geo. General Hospital</b>		<b>23d. LOCATION (City, town or county)</b> <b>(State)</b> <b>Cheverly, P.G. County, Md.</b>	
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>HARRY W. PENN</b>				<b>25a. REC'D BY REGISTRAR</b> <b>APR 18 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

-2077193 XV2

(M)

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*[Handwritten signature]*

*[Faint handwritten text]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, give nearest town) <u>Chantilly</u> <u>D. C. A.</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert Lee</u> <u>HALL</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1961</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 22, 1927</u>	9. AGE (In years last birthday) <u>33</u> yrs.	IF UNDER 1 YEAR: Months <u></u> Days <u></u> IF UNDER 24 HRS: Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during last of working time, even if retired) <u>Contributor</u>		10b. KIND OF BUSINESS OR INDUSTRY (Town) <u>Boeing</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u> <u>U. S. A.</u>			
13. FATHER'S NAME <u>Robert Lee Hall Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Shugruff</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Dr. Richard L. Sylvester</u> Address <u>3140 Knaplake Wash. D.C.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> <u>823X</u> DUE TO (b) <u>Fracture of base of skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>crushed chest</u> INTERVAL BETWEEN ONSET AND DEATH <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Occupant of an auto driven off road and struck by a fixed object</u>					
20c. TIME OF INJURY Month, Day, Year <u>10:00 a.m. April 9, 1961</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road</u>	20f. (City or town) <u>meadows Pk.</u> (County) <u>Ind</u> (State) <u></u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u></u>							
ACTUAL SIGNATURE <u>James I. Boyd</u>		DATE SIGNED <u>April 10, 1961</u>					
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/13/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>	22d. LOCATION (City, town, or country) <u>Upper Marlboro Md.</u>	(State) <u></u>			
23. FUNERAL DIRECTOR ADDRESS <u>Ritchie Bros. Fun'l Home-Upper Marlboro.</u>		24a. REC'D BY REGISTRAR <u>MAY 1 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>				



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John W. Hall

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12th of June 1895

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James T. Smith

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

4655

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General</b>		d. STREET ADDRESS <b>5802 Sheriff Road</b>	
3. NAME OF DECEASED (Type or print) <b>Alfred Ignatious Hamilton</b>		4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1906</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William H. Hamilton</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jackson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Dorothy L. Hamilton, Same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> <b>919.6</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gun shot wound in the thigh and pelvis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by a revolver that fell to the ground</b>	
20c. TIME OF INJURY Month, Day, Year <b>12:00 AM 4/16/1961</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Tavern</b>	20f. (City or town) (County) (State) <b>Chapel Oaks P. G. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>4/16/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-19-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Carverman Park</b>	22d. LOCATION (City, town, or country) (State) <b>Laurel, Md.</b>
23. FUNERAL DIRECTOR <b>Barnes &amp; Matthews</b> ADDRESS <b>3619-14th St NW</b>		24a. REC'D BY REGISTRAR <b>APR 18 '61</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

MEDICAL CERTIFICATION

M.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 7 be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4656 CERTIFICATE OF DEATH 04643											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY -					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN 1b 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital						d. STREET ADDRESS 1217 Orren St., N. E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James C. Harris						4. DATE OF DEATH Month Day Year 4 7 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/13/03		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction worker				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) Fla.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Henry Harris						14. MOTHER'S MAIDEN NAME Catherine Cox Harris					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 579-01-2927		17. INFORMANT Decedent Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right pneumothorax DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far advanced pulmonary tuberculosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema; subtotal gastrectomy, 1953										INTERVAL BETWEEN ONSET AND DEATH 48 hrs., 14 yrs.,	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/17 1961 to 4/7 1961, that (I) (we) last saw the deceased alive on 4/7 1961, and that death occurred at a. M. from the causes and on the date stated above.											
22a. SIGNATURE William J. Washington, Jr. M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/7/61			
22c. PHYSICIAN'S NAME (Type) William J. Washington, Jr., MD						22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10 APR 1961		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY				23d. LOCATION (City, town or county) (State) BLADENSBURG, MD.			
24. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME WASH. D.C.				ADDRESS 816-H ST. N.E.		25a. REC'D BY REGISTRAR DATE APR 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

(M)

(1)

Washington, D.C.

1942

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04644

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		d. STREET ADDRESS 529 Chestnut St	
3. NAME OF DECEASED (Type or print) Lillie First Middle Last Hawkins		4. DATE OF DEATH April 28 1961	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1891
9. AGE (In years, months, days, hours, minutes) 69 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Francis Fletcher		14. MOTHER'S MARDEN NAME Mary Brooks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Ruth Nickson		Address Bowie	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Congestive Heart Failure DUE TO (b) Hypertension DUE TO (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 wks 6 yrs 15 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1955, to April 28, 1961, that (I) last saw the deceased alive on 4/28 1961, and that death occurred about 5:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Henry A. Wise, Jr.		22b. DATE SIGNED 4/28/61	
22c. PHYSICIAN'S NAME (Type) Henry A. Wise, Jr.		22d. ADDRESS Bowie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-3-61	
23c. NAME OF CEMETERY OR CREMATORY Church of Ascension		23d. LOCATION (City, town, or county) (State) Bowie Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Barnes & Matthews		25a. REC'D BY REGISTRAR MAY 1 '61	
ADDRESS 2619-1411 St. N. W. 40		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

For the sum of Five Hundred Dollars (\$500.00)  
to the order of John Doe  
Five Percent  
Dated April 1, 1964  
This certificate represents the deposit of the sum of Five Hundred Dollars (\$500.00) in the American State Bank of New York, Memphis, Tennessee, for the term of Five (5) years, at the rate of Five Percent (5%) per annum, payable quarterly.

CHIEF CLERK

2002-1-1000

AMERICAN STATE BANK OF NEW YORK

MEMPHIS, TENN. 38002

APR 1 1964

JOHN DOE

FIVE HUNDOLARS

FIVE PERCENT

APR 1 1964

AMERICAN STATE BANK OF NEW YORK

MEMPHIS, TENN. 38002

APR 1 1964

JOHN DOE

FIVE HUNDOLARS

FIVE PERCENT

APR 1 1964

AMERICAN STATE BANK OF NEW YORK

MEMPHIS, TENN. 38002

APR 1 1964

JOHN DOE

FIVE HUNDOLARS

FIVE PERCENT

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

<div>Items 20&amp;21 Film 287 202651 ans</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>Item 18, Film G-287 5/15/61.cac.</div> <div>04645</div>											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE				b. COUNTY			
Prince George's MARYLAND				Maryland				Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
Hyattsville 5 years								Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3900 Hamilton				3900 Hamilton							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
First Middle Last				Month Day Year							
Ella Callahan Herring				April 29 1961							
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		August 10, 1892		68 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
House Wife				Own Home				Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
Samuel Callahan				Emma Long				U. S. A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
No				578-18-3512				Mr. Daniel W Herring, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 871.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pending DUE TO Acute intoxication due to Placedyl. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Took an overdose of Placedyl. Was mentally disturbed.							
20c. TIME OF INJURY Month, Day, Year Hour a.m. xxx 4-29- 19 61				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hyattsville P.G. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
James I. Boyd				Address (Street, city, town, or county)				4/29/61			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)			
Burial				5/2/61		Arlington National		Arlington, Virginia			
23. FUNERAL DIRECTOR ADDRESS						24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE					
W.W. Chambers Co. 5801 Cleveland Ave. Riverdale Maryland						DATE MAY 3 '61 Arthur L. Hines					

MEDICAL CERTIFICATION

1. *Journal of the American Medical Association*, 1997; 277: 1033-1038.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4659

04646

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Pr Geo</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick, Md.</u>		c. LENGTH OF STAY in lb <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eugene Teland Memorial Hosp</u>				d. STREET ADDRESS <u>4708 - Indian Lane</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>EDWARD DONALD Hickey</u>				<b>4. DATE OF DEATH</b> Month <u>APR</u> Day <u>24</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Aug 22, 1915</u>		<b>9. AGE</b> (In years last birthday) <u>45</u> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Automotive Foreman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Store</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Bethel Conn.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Morris Hickey</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input checked="" type="checkbox"/> <u>W. War II 9/2/45</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>045-10-3341</u>				<b>17. INFORMANT</b> <u>Evelyn Hickey same</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>434.1</u> DUE TO <u>Acute Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Nov</u>			
<b>20f. (City or town)</b> <u>Nov</u>		<b>20g. (County)</b> <u>Nov</u>		<b>20h. (State)</b> <u>Nov</u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov 1960</u> <b>to</b> <u>APR 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>APR 22 1961</u> <b>and that death occurred at</b> <u>11 A.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>W. L. Etienne</u>				<b>22b. DATE SIGNED</b> <u>4/24/61</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>W. L. ETIENNE</u>				<b>22d. ADDRESS</b> <u>College Park, Md</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>4/27/61</u>		<b>23c. NAME OF CEMETERY OR INTERMENT</b> <u>Arlington National</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Arlington Va</u>		<b>23e. (State)</b> <u>Va</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F. Gasch's Sons Hyattsville Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>APR 26 '61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thrall</u>				<b>25c. DATE</b> <u>APR 26 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4660

04647

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>43 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>John A Hines</b>				<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>30</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1 Jan. 1910</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Surveyor</b>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>51 yrs.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Francis M Hines</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Wood</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>			
17. INFORMANT <b>Genevieve A Hines</b>				Address <b>Lanham, Maryland.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE G.I. BLEEDING</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>ESOPHAGEAL VARICOSITIES</b> (c) <b>CIRRHOSIS OF THE LIVER</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3/17/61</b> <b>3 yrs.</b> <b>5 yrs.</b>							
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from <b>3/17</b>, 19<b>61</b>, to <b>4/30</b>, 19<b>61</b>, that (I) <del>(we)</del> last saw the deceased alive on <b>4/29</b>, 19<b>61</b>, and that death occurred at <b>7:45 AM</b> from the causes and on the date stated above.</b>							
22a. SIGNATURE <b>Dr. Frederick Musser, Md.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Frederick Musser, Md.</b>				22d. ADDRESS <b>4410 74th Ave. Bellemeade, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 3, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 3 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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## CERTIFICATE OF DEATH

Reg. Dist. No. 4648

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If in a. STATE <u>District of Columbia</u> n. Residence bldg. admission) <u>477x3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green Meadows, Hyattsville 6 weeks</u>		c. CITY OR TOWN (If inside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bells Nursing Home for Children</u>		d. STREET ADDRESS <u>5002 - 12th St. N.E.</u>	
3. NAME OF DECEASED (Type or print) <u>Bertha May Hubbard</u> First Middle Last		4. DATE OF DEATH <u>April 11th</u> 19 <u>61</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/60</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	9c. BIRTHPLACE (State or foreign country) <u>U.S.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	10c. BIRTHPLACE (State or foreign country) <u>U.S.</u>
11. FATHER'S NAME <u>Douglas B. Hubbard</u>		12. MOTHER'S MAIDEN NAME <u>Mary L. Steele</u>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		14. SOCIAL SECURITY NO. <u>—</u>	
15. INFORMANT <u>Mary L. Hubbard, mother</u>		Address <u>above</u>	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus,</u> <u>344X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
17. INTERVAL BETWEEN ONSET AND DEATH <u>5 mos +</u>			
18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>61</u> , to <u>present</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>April 14th</u> , 19 <u>61</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Trozzo Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>3501 Hamilton St</u> DATE SIGNED <u>4/11/61</u>	
PHYSICIAN'S NAME (Type) <u>FRANK M. TROZZO JR.</u>		<u>Hyattsville, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4/14/61</u>	<u>St. Elizabeth</u>	<u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Waller's Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>APR 17 '61</u>	
ADDRESS <u>Waller's Funeral Home</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

COMMITTEE OF SENATE

1891

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page.]*

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

04649

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's County</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>951 Eastwest Highway Apt. 31</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Takoma Park</b> d. STREET ADDRESS <b>951 Eastwest Highway Apt. 31</b>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>VICTOR WARD HUNSINGER</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>14</b> Year <b>19 61.</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>					
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>January 20, 1961</b>					
<b>9. AGE</b> (In years last birthday) <b>3</b> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Child</b>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months Days	Hours Min.						
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Infant</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Peoria, Illinois</b>					
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Melvin Frank Hunsinger</b>					
<b>14. MOTHER'S MAIDEN NAME</b> <b>Virginia Lee Collins</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No None None</b>					
<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> Address <b>951 Eastwest Highway Apt. 31, Takoma Park, Md.</b> <b>Mr. Melvin F. Hunsinger</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA, bilateral</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <b>JAMES I. BOYD, M.D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
<b>EXAMINER'S NAME (Type)</b> <b>JAMES I. BOYD, M.D.</b>		<b>DATE SIGNED</b> <b>April 14, 1961</b>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>April 17, 1961</b>					
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Spring Bay Cemetery</b>		<b>22d. LOCATION (City, town, or country)</b> (State) <b>Spring Bay, Woodford, Cty, Illinois.</b>					
<b>23. FUNERAL DIRECTOR</b> <b>W. W. CHAMBERS CO.,</b>		<b>24a. REC'D BY REGISTRAR</b> <b>APR 17 '61</b>					
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kneass</b>							

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1941, 20 JANUARY

Virginia Lee Collins

REPORT OF THE

feet, Al. Dry.

JUN 19 1943

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04650

4663

<b>1. PLACE OF DEATH</b> e. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>39 Hrs 20 Min</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>USAF HOSP, ANDREWS AFB, MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> d. STREET ADDRESS <b>1201 VALLEY AVENUE, S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <b>PETER GEOFFREY HUNTLEY</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>APRIL 22 19 61</b>		<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>CAUCASIAN</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>21 APRIL 1961</b>		<b>9. AGE</b> (In years last birthday) yrs. Months Days <b>— — 1</b>		<b>IF UNDER 1 YEAR</b> Months Days <b>— — 1</b>		<b>IF UNDER 24 HRS.</b> Hours Min. <b>39 20</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>NONE</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>NONE</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>UNITED STATES</b>					
<b>13. FATHER'S NAME</b> <b>RICHARD L. HUNTLEY</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>JO ANN EXUM</b>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> <b>FATHER</b>				Address <b>SAME AS ITEM #2</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PREMATURITY</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>ATELECTASIS, CONGENITAL, BILATERAL</b> DUE TO (c) <b>SUBARACHNOIC HEMORRHAGE, MODERATELY SEVERE</b>														INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>Washington D.C.</b>		(County)		(State)					
<b>21. I certify that</b> <del>the</del> (this hospital) attended the deceased from <b>21 April 1961</b> to <b>22 April 1961</b> , that <del>the</del> (we) last saw the deceased alive on <b>22 April 1961</b> , and that death occurred at <b>7:30P</b> , from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> <i>Nicholas P. Haritos</i> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <b>22 April 61</b>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>NICHOLAS P HARITOS, CAPT USAF MC</b>						<b>22d. ADDRESS</b> <b>USAF HOSP, ANDREWS AIR FORCE BASE, MD.</b>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>unknown</b>				<b>23b. DATE THEREOF</b> <b>unknown</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>D.C. Morgue</b>				<b>23d. LOCATION</b> (City, town or county) (State) <b>Washington D.C.</b>					
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>ADDRESS</b>						<b>25a. REC'D BY REGISTRAR</b> <b>DATE APR 27 '61</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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PRINCE GEORGES

DISTRICT OF COLUMBIA

ANDREWS AIR FORCE BASE 99 Hrs 30 Min

WASHINGTON

USAF HOSP, ANDREWS AFB, MARYLAND

12-1 VALLEY VIEW, S. D.

WHITE

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RICHARD I. HUNTER

JO ANN KYLE

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ATLANTIC, CONCENTRAL, ALL TOWNS

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21 April

22 April 61

RICHARD I. HUNTER, ANDREWS AIR FORCE BASE, MD.

*Handwritten signatures and notes:*  
B.C. Morgan  
Morgan, B.C.  
22 April 61

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
4664 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04651

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A.			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 5722 39th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Carolyn DeEtte Hyde			4. DATE OF DEATH Month Day Year April 2 1961		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1900	9. AGE (in years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY D. C. Government		11. BIRTHPLACE (State or foreign country) District of Columbia	
13. FATHER'S NAME Claude Thornburg			14. MOTHER'S MAIDEN NAME Clara <del>KSEMA</del> Bremerman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or date of service)		17. INFORMANT George Roger Hyde, same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute congestive heart failure DUE TO (b) Coronary arterial heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 2, 1961 Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/61		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	
22d. LOCATION (City, town, or country) Washington D. C.		22e. (State)			
23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.			24a. REC'D BY REGISTRAR DATE APR 6 '61		
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

MEDICAL CERTIFICATION

THE STATE  
OF MISSISSIPPI



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May 1, 1905

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U. S. Government

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Prison Record

George Rogers, aged 22

Prison Record

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Washington D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
4665  
CERTIFICATE OF DEATH

04652

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE</u>				c. LENGTH OF STAY IN 1b <u>2 MONTHS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>—</u>				e. STREET ADDRESS <u>15906 TAYLOR RD.</u>			
3. NAME OF DECEASED (Type or print) <u>ANNA MARY JOHNSON</u>				4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-29-1893</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>272-16-2697</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Alfred STOVER</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA WEIGERT STOVER?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT <u>SEALD JOHNSON</u> Address <u>5906 TAYLOR RD. RIVERDALE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF GALL BLADDER</u> 155-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>155-1</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>2 MONTHS</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/19</u> , 19 <u>61</u> , to <u>4/21</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4/20</u> , 19 <u>61</u> , and that death occurred <u>2:10 A.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>C. G. Hardy</u>				22b. DATE SIGNED <u>4/21/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>C. GEORGE HARDY</u>				22d. ADDRESS <u>6827 ANNAPOLIS RD. LANDOVER HILLS MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr. 23, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairfax</u>		23d. LOCATION (City, town or county) (State) <u>Fairfax, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Everly Funeral Home</u> By <u>Mr.</u>				ADDRESS <u>Fairfax, Virginia</u>		25a. REC'D BY REGISTRAR DATE <u>APR 24 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Clayton S. Harris</u>	

(M)

(I)

Frank White

225-16-5077 - 2nd fl.

John Alfred Stone

2nd fl.

Volunteer, Virginia

Volunteer

Apr. 29, 1961

Volunteer

Volunteer, Virginia

Volunteer, Virginia

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TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
04653

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 2020 20th St., S. E.	
3. NAME OF DECEASED (Type or print) Jackie L. Johnson		4. DATE OF DEATH 4 8 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> but separated <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) 42 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (County & State, or foreign country) Colorado
13. FATHER'S NAME James Mann		14. MOTHER'S MAIDEN NAME Laura Petts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown (lost)	17. INFORMANT Decedent
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laennec's cirrhosis of the liver, decompensated DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO			INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Bronchopneumonia, left lower lobe; chronic alcoholism			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/27/1961, to 4/8/1961, that (I) (we) last saw the deceased alive on 4/8/1961, and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 4/8/61	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 4/12/61	23c. NAME OF CEMETERY OR CREMATORY D.C. Morgue	23d. LOCATION (City, town or county) (State) Washington D. C.
24. FUNERAL DIRECTOR'S SIGNATURE Moe Weiss M.D. by William J. Ashington Jr. Glenn Dale Hospital		25. REC'D BY REGISTRAR APR 17 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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STATE OF NEW YORK

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Office of the

State Engineer

Albany, N. Y.

January 1, 1900

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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## CERTIFICATE OF DEATH

Reg. Dist. No. 04654

1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>same</u> b. COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5493 - Kennyside Ave</u>		d. STREET ADDRESS <u>same</u>	
3. NAME OF DECEASED (Type or print) <u>UPTON</u> <sup>First</sup> <u>(None)</u> <sup>Middle</sup> <u>JONES</u> <sup>Last</sup>		4. DATE OF DEATH <u>APRIL 7</u> <sup>Month</sup> <u>1961</u> <sup>Day</sup> <sup>Year</sup>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 25, 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Dairyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>John P Jones</u>		Address <u>College Park, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>Declarative Ischemic Heart Disease</u> IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>2 decompensation</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>Open Atherosclerosis</u> (b) <u>Open Atherosclerosis</u> (c) <u>Open Atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>College Park, Md.</u>	20f. (City or town) <u>College Park</u> (County) <u>Pr Geo</u> (State) <u>Md.</u>
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>50</u> , to <u>April 12, 1961</u> , that I last saw the deceased alive on <u>MAR 31, 1961</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.C. Etienne</u> M.D.		DATE SIGNED <u>4/13/61</u>	
PHYSICIAN'S NAME (Type) <u>W.C. ETIENNE</u>		ADDRESS <u>College Park, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 10, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>	22d. LOCATION (City, town, or county) <u>Beltsville, Md.</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 11 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Richard E. Knaus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
4668 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04655

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HILLCREST HEIGHTS</b> c. LENGTH OF STAY IN 1b <b>10 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5845 - 28th. AVENUE</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HILLCREST HEIGHTS</b> d. STREET ADDRESS <b>5845 - 28th., AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>MONROE JAMES KELLEY, SR.</b>		4. DATE OF DEATH <b>APRIL 15, 1961</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 12th. 1897</b>		9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HEAVY EQUIPMENT OPERATOR</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>				11. BIRTHPLACE (State or foreign country) <b>ARKANSAS</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>ALFRED KELLEY</b>				14. MOTHER'S MAIDEN NAME <b>unknown HOLLEY</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service) <b>NONE</b>				16. SOCIAL SECURITY NO. <b>702-09-6953</b>				17. INFORMANT <b>Mrs. Edith Kelley</b> Address <b>Same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Arterial heart disease</b> (a), stating the underlying cause, test. DUE TO (c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				DATE SIGNED <b>APRIL 15th., 1961</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4/20/1961</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Dexter Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Pine Bluff, Ark.</b>							
23. FUNERAL DIRECTOR <b>W.W. Chambers Co., 517--11th St. S.E. Wash. DC</b>								24a. REC'D BY REGISTRAR <b>APR 18 '61</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

MEDICAL CERTIFICATION

FOR STATE  
RECORDS  
(M)

(I)

ALBANY, N.Y.  
JANUARY 1, 1901

300 - 300, AVENUE  
ALBANY

WHITE  
HEAVY BUILT, CLEAN

ALBANY, N.Y.  
JANUARY 1, 1901

300 - 300, AVENUE  
ALBANY

WHITE  
HEAVY BUILT, CLEAN

ALBANY, N.Y.  
JANUARY 1, 1901

300 - 300, AVENUE  
ALBANY

WHITE  
HEAVY BUILT, CLEAN

ALBANY, N.Y.  
JANUARY 1, 1901

ALBANY, N.Y.  
JANUARY 1, 1901

300 - 300, AVENUE  
ALBANY

WHITE  
HEAVY BUILT, CLEAN

ALBANY, N.Y.  
JANUARY 1, 1901

300 - 300, AVENUE  
ALBANY

WHITE  
HEAVY BUILT, CLEAN

ALBANY, N.Y.  
JANUARY 1, 1901

300 - 300, AVENUE  
ALBANY

WHITE  
HEAVY BUILT, CLEAN

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JANUARY 1, 1901

ALBANY, N.Y.  
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HEAVY BUILT, CLEAN

ALBANY, N.Y.  
JANUARY 1, 1901

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JANUARY 1, 1901

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JANUARY 1, 1901

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300 - 300, AVENUE  
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WHITE  
HEAVY BUILT, CLEAN

ALBANY, N.Y.  
JANUARY 1, 1901

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WHITE  
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ALBANY, N.Y.  
JANUARY 1, 1901

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ALBANY

WHITE  
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ALBANY, N.Y.  
JANUARY 1, 1901

ALBANY, N.Y.  
JANUARY 1, 1901

300 - 300, AVENUE  
ALBANY

WHITE  
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ALBANY, N.Y.  
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ALBANY, N.Y.  
JANUARY 1, 1901

300 - 300, AVENUE  
ALBANY

WHITE  
HEAVY BUILT, CLEAN

ALBANY, N.Y.  
JANUARY 1, 1901

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4669  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>01</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ireland Memorial Hospital</b>		d. STREET ADDRESS <b>4408 Queenbury Rd</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Cassell Charles Kercheval</b>		4. DATE OF DEATH <b>4-6-1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-30-85</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Va.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Kercheval John W.</b>		14. MOTHER'S MAIDEN NAME <b>Willie Ann Stolle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Wife</b>	
17. INFORMANT <b>Wife</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446X</b> DUE TO <b>Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Nephrosclerosis</b> DUE TO <b>Generalized Arteriosclerosis</b> (c) <b>Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Thrombosis</b> <b>Myocardial</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Myocardial Infarction</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1953</b> to <b>April 6</b> , that (I) (we) lost saw the deceased alive on <b>April 5</b> , 19 <b>61</b> , and that death occurred at <b>2:25</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert L. Thompson</b>		22b. DATE SIGNED <b>April 6, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Samuel Maryland</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-9-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Green Hill - Berryville</b>		23d. LOCATION (City, town, or county) (State) <b>Berryville, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles J. Enders</b>		25a. REC'D BY REGISTRAR <b>APR 7 '61</b>	
ADDRESS <b>Berryville, Va.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Enders</b>	

1912

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*Female*

*[Faint, mostly illegible handwritten text follows, likely containing personal and medical details.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4670 Item 5 Film G287 5/15/61 iwk 05967											
1. PLACE OF DEATH a. COUNTY <b>Prince George</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Pa.</b>				b. COUNTY <b>Philadelph</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>4 Hours</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Philadelphia 19</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General</b>				d. STREET ADDRESS <b>721 East Phil Ellana St</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Frederica Knup</b>				4. DATE OF DEATH <b>April 5, 1961</b>				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/7/75</b>		9. AGE (in years last birthday) <b>86 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Switzerland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Albert Thommen</b>				14. MOTHER'S MAIDEN NAME <b>Frederica Bettke</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>				17. INFORMANT <b>Hospital Records, Cheverly, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Cerebral vascular accident</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>cerebral arterio-sclerosis</b> (c) <b>hypotension cardiovascular disease</b>				19. INTERVAL BETWEEN ONSET AND DEATH <b>7h</b> <b>yes</b>				20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Hyattsville, Md.</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-5-61</b> , 1961, to <b>4-5-61</b> , 1961, that (I) (we) last saw the deceased alive on <b>4-5-61</b> , 1961, and that death occurred at <b>7:40PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Till Bergemann</b>				22b. DATE SIGNED <b>April 5, 1961</b>				22c. PHYSICIAN'S NAME (Type) <b>Till Bergemann</b>			
22d. ADDRESS <b>Hyattsville, Md.</b>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/>				22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/8/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillside Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Roslyn - Duma</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Krasche sons Hyattsville Md</b>				25a. REC'D BY REGISTRAR <b>APR 10 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04657

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4 Mt. Rainier</b>			
c. LENGTH OF STAY IN 1b <b>D.O.A.</b>				d. STREET ADDRESS <b>3364 Chillum Road</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Ann</b> Last <b>Konosky</b>				4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 18, 1952</b>	
9. AGE (In years last birthday) <b>8</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Carl Andrew Konosky</b>				14. MOTHER'S MAIDEN NAME <b>Mary Louise Thomas</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Carl Andrew Konosky, same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334X SEVERE EDEMA OF BRAIN AND SPINAL CORD</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>April 8, 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE OF BURIAL <b>4/8/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	
22d. LOCATION (City, town, or country) (State) <b>Washington, D.C.</b>							
23. FUNERAL DIRECTOR <b>Halley's Funeral Home Inc.</b>				ADDRESS <b>Mt. Rainier Md.</b>		24a. REC'D BY REGISTRAR <b>APR 12 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

THE STATE  
HEALTH DEPT.



MAINTAINING STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Name: George J. ...  
Age: 50...  
Sex: Male  
Race: ...  
Date of Birth: ...  
Place of Birth: ...  
Cause of Death: ...  
Manner of Death: ...  
Signature: ...  
Date: ...  
U.S.A.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
4672 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
04658									
1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Riverdale 66			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 6109 Mustang Place				
3. NAME OF DECEASED (Type or print) First AUGUST Middle LUDWIG Last LANGE					4. DATE OF DEATH Month April Day 2, Year 19 61.				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 30, 1889 72 yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner, Resturant, Ret.				10b. KIND OF BUSINESS OR INDUSTRY Resturant		11. BIRTHPLACE (State or foreign country) Meriden, Connecticut		12. CITIZEN OF WHAT COUNTRY? US.A	
13. FATHER'S NAME Ferdiand Lange					14. MOTHER'S MAIDEN NAME Hilda Vadapole				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No None					16. SOCIAL SECURITY NO. <del>574-242716</del> INSURANT Address 2701 R Street S.E. Wash., D.C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary arteriosclerosis (a), stating the underlying cause last. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 2, 1961.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 4/6/61		22c. NAME OF CEMETERY OR CREMATORY Bonaventure		22d. LOCATION (City, town, or country) Meriden, Conn.		
23. FUNERAL DIRECTOR Nalley's Funeral Home Inc.					24a. REC'D BY REGISTRAR DATE APR 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
4673  
CERTIFICATE OF DEATH

04659

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN IB <b>4 hrs</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>6204 L St.</b>			
3. NAME OF DECEASED (Type or print) <b>Baby</b> <b>Boy</b> <b>Lee</b>				4. DATE OF DEATH <b>April 9 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9 April 1961</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles</b>				14. MOTHER'S MAIDEN NAME <b>Dorothy Gaylord</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mother</b> <b>Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Atelidase</b> <b>Prematurity</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9 Apr. 1961</b> to <b>9 Apr. 1961</b> that (I) (we) last saw the deceased alive on <b>9 Apr. 1961</b> and that death occurred at <b>1:30 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John W. Perkins</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4-10-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John Perkins. M.D.</b>				22d. ADDRESS <b>5301 Hamilton St. Hyattsville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>4/17/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pr. Geo. General Hospital</b>		23d. LOCATION (City, town or county) (State) <b>Cheverly, P. G. County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HARRY W. PENN</b>				ADDRESS <b>2077 215 XVO</b>		25a. REC'D BY REGISTRAR <b>APR 18 61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

(M)

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Handy W. ...  
...

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been retained by the attending physician and completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4674

04660

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>10 Hours</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> d. STREET ADDRESS <b>3106 Parkway</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Margaret</b>			4. DATE OF DEATH <b>April 20 19 61</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Apr. 20, 1885</b>		9. AGE (In years last birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Thomas P Davis</b>		14. MOTHER'S MAIDEN NAME <b>Herbic</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Benjamin R Lemke Cheverly, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO (b) <b>Occlusion of coronary artery</b> DUE TO (c) <b>Hypertensive arteriosclerotic Cardiovascular disease</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>420.1</b> INTERVAL BETWEEN ONSET OF DEATH <b>4 days</b> <b>4 days</b> <b>10 yrs.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (his hospital) attended the deceased from <b>April 19 19 61</b> to <b>Apr. 20 19 61</b> , that (I) (we) last saw the deceased alive on <b>April 19 19 61</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Julius Kauffman</b>		22b. DATE <b>4/20/61</b>		22c. ADDRESS <b>5102 ANNAPOLIS RD BLADENSBURG, MD</b>	
22d. PHYSICIAN'S NAME (Type) <b>JULIUS KAUFFMAN, M.D.</b>		22e. ADDRESS <b>5102 ANNAPOLIS RD BLADENSBURG, MD</b>		22f. ADDRESS <b>5102 ANNAPOLIS RD BLADENSBURG, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 24, 1961</b>		23c. NAME OF CEMETERY OR <b>Arlington National</b>	
23d. LOCATION (City, town or county) <b>Arlington Va.</b>		23e. LOCATION (State) <b>VA.</b>		23f. LOCATION (Country) <b>USA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. ADDRESS <b>Hyatts ville, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 24 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>		25c. ADDRESS <b>Hyatts ville, Maryland</b>		25d. ADDRESS <b>Hyatts ville, Maryland</b>	

(M)

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Benjamin A. Davis, Jr.  
1941

April 14, 1941

Washington V.I.

April 14, 1941

Washington V.I.

April 14, 1941

Washington V.I.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Items 8 & 9 Film 6287 5/15/61

4675

04661

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (RURAL)</b>			c. LENGTH OF STAY IN 1b <b>1 mo, 5 days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>			d. STREET ADDRESS <b>2914 - 18th St., N.W.</b>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Benjamin A Levine</b>			4. DATE OF DEATH Month Day Year <b>April 26 1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/9/1894</b>	9. AGE (In years last birthday) <b>64 66 yrs.</b>	IF UNDER 1 YEAR Months Days <b>64 66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired salesman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Trading Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York, New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>William N. Levine</b>		
14. MOTHER'S MAIDEN NAME <b>Bessie Mallomsky</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>130-12-7541</b>			17. INFORMANT <b>Decedent</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO (b) <b>Acute myocardial infarction, left ventricle</b> DUE TO (c) <b>Severe atherosclerotic coronary artery disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus; pulmonary tuberculosis; left mid-thigh amputation due to gangrene 4/21/61; generalized peripheral arteriosclerotic disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>19</b>		20g. (County) <b>19</b>		20h. (State) <b>19</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>3/20/61</b> to <b>4/26</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/26</b> , 19 <b>61</b> , and that death occurred at <b>8:30</b> AM, from the causes and on the date stated above.					
22a. SIGNATURE <b>Moe Weiss</b>			22b. DATE SIGNED <b>4/26/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss</b>			22d. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-30-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Park Ceme</b>	
23d. LOCATION (City, town or county) <b>Oradell, N.J.</b>		23e. REC'D BY REGISTRAR <b>APR 28 '61</b>		23f. REGISTRAR'S SIGNATURE <b>Charles S. ...</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Soldberg Funeral Home</b>					
25. ADDRESS <b>4217-92nd Ave</b>					

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Glenn Dale Hospital

Glenn Dale Hospital

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New York, N.Y.

William W. Davis

Business University

William W. Davis

Washington

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Comprehensive Report

Latin American Report

Business University

Business University

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Glenn Dale Hospital

may be retained in the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

4676

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04662

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKLAND</u>				c. LENGTH OF STAY IN 1b <u>25 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u># 26-Kentucky</u>				d. STREET ADDRESS <u>#26 KENTUCKY AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAMIE E. Lewis</u>				4. DATE OF DEATH Month Day Year <u>4-28-1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN-29-1883</u> 78 yrs.	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Young</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN HOPPER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>26 KENTUCKY AVE PARKLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c) <u>Cerebral Thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/25</u> 19 <u>61</u> to <u>4/28</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4/27</u> 19 <u>61</u> , and that death occurred at <u>3:45</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Lewis Parker</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>LEWIS PARKER</u>	
22d. ADDRESS <u>5241- St Barnabas Rd S E</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>May 1-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		23d. LOCATION (City, town, or county) (State) <u>Smithland Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ammon Buss</u> ADDRESS <u>1661 Gd Hope Rd Washington DC S E</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

(M)

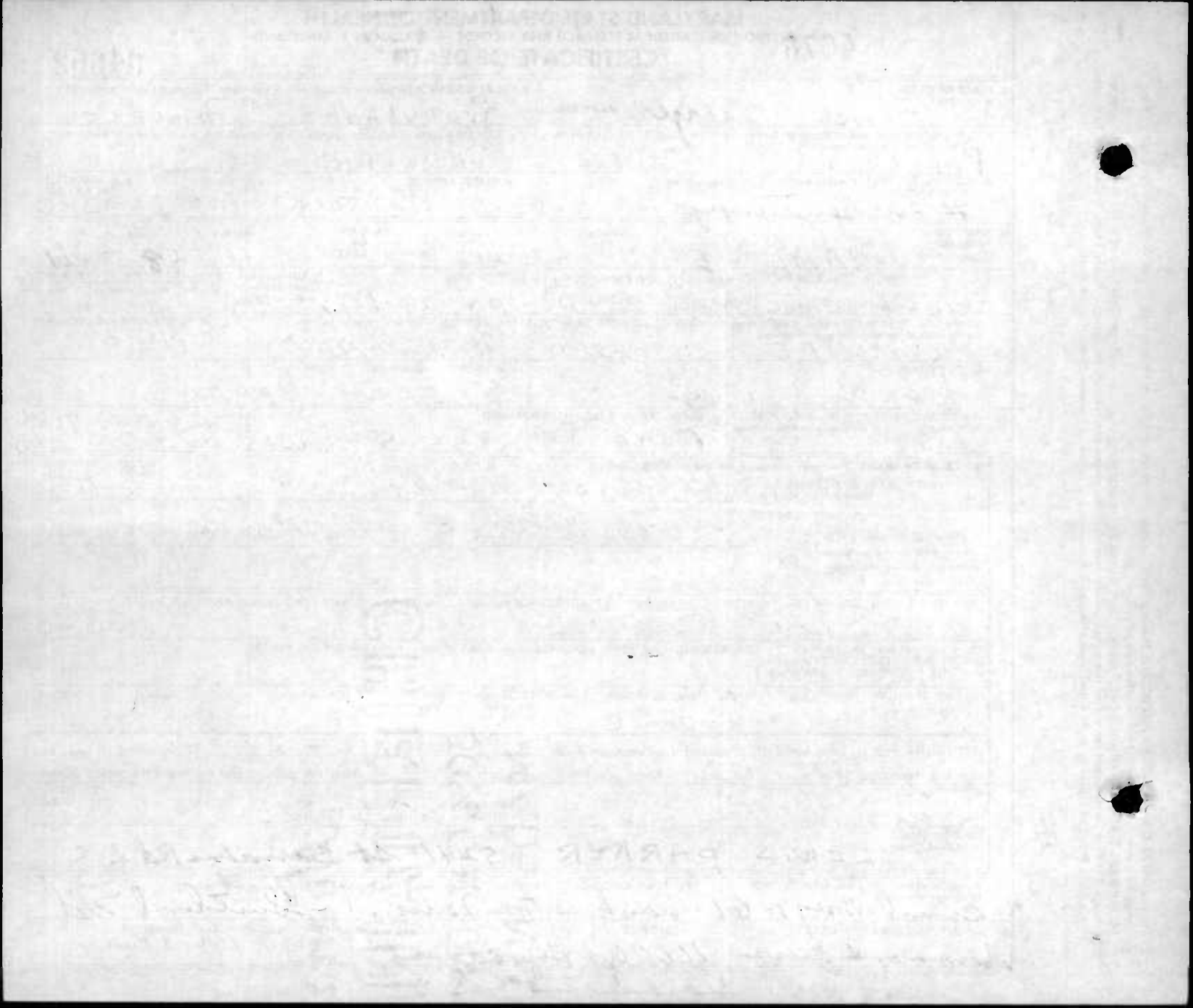
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(I)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4677

## CERTIFICATE OF DEATH

04663

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b> d. STREET ADDRESS <b>32 Roosevelt Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Winslow K Liverette</b>		4. DATE OF DEATH Month Day Year <b>Apr. 16 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-29-1901* 1901</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Liverette</b>		14. MOTHER'S MAIDEN NAME <b>Roxy West</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>UNK.</b>	
17. INFORMANT <b>Nettie Liverette</b>		Address <b>above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mediastinitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>150X</b> (b) <b>Surgical resection of the esophagus</b> (c) <b>Epidermoid Carcinoma of the Esophagus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 week</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 22 1961</b> , to <b>Apr. 16 1961</b> , that (I) (we) last saw the deceased alive on <b>Apr. 16 1961</b> , and that death occurred <b>3:20 P</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>George William Ware</b>		22b. DATE <b>Apr. 17, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>George William Ware</b>		22d. ADDRESS <b>1835 Eye St NW.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 20, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tattarall Funeral Home</b>		25a. REC'D BY REGISTRAR <b>APR 19 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. ADDRESS <b>3603-14 St NW</b>	

(M)

(I)

James Liverie

Box 100

Nettie Liverie

above

George William

Apr. 20, 1907

Amherst, Vt.

THE UNIVERSITY OF CHICAGO PRESS

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
4678 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
04664									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE North Carolina b. COUNTY Robinson				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) T. B.					c. LENGTH OF STAY IN lb D.O.A.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dobson Clinic					d. STREET ADDRESS Maxton Route # 1				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Inman			First Middle Last Locklear			4. DATE OF DEATH April 1, 1961		Month Day Year	
5. SEX Male		6. COLOR OR RACE Red		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1927		9. AGE (In years last birthday) 33	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U. S. Army		11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Oscar Locklear					14. MOTHER'S MAIDEN NAME Rita Rettie McGirt				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. (If yes give year or dates of service) Last 6 years		17. INFORMANT U. S. Army Records			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE AND SHOCK DUE TO GUNSHOT WOUND OF CHEST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Shot during an altercation						
20c. TIME OF INJURY 12:05 p.m. April 1, 1961			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Public Park		20f. (City or town) Brandywine P. G.		(County) (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE James I. Boyd			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			DATE SIGNED 4/1/61
EXAMINER'S NAME (Type) James I. Boyd			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7 APR. 1961		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) MAXTON No. CAR.		(State)	
23. FUNERAL DIRECTOR RINALDI FUNERAL HOME 816 H ST. N.E., N.C. 2					24a. REC'D BY REGISTRAR DATE APR 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna		



UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF MEDICAL SERVICE  
WASHINGTON, D. C.

REPORT OF THE CHIEF OF MEDICAL SERVICE  
ON THE MEDICAL SITUATION IN THE ARMY

1. The medical situation in the Army is generally satisfactory.

2. The medical service is well organized and efficient.

3. The medical service is well equipped and well supplied.

4. The medical service is well trained and well motivated.

5. The medical service is well coordinated and well integrated.

6. The medical service is well managed and well controlled.

7. The medical service is well maintained and well preserved.

8. The medical service is well developed and well improved.

9. The medical service is well advanced and well progressing.

10. The medical service is well established and well founded.

11. The medical service is well organized and well planned.

12. The medical service is well executed and well completed.

13. The medical service is well finished and well perfected.

14. The medical service is well accomplished and well achieved.

# 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4673 *Punice, Georgia Co.* CERTIFICATE OF DEATH

Reg. Dist. No. *04665*

1. PLACE OF DEATH a. COUNTY <i>HYATTSVILLE</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Hyattsville</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HYATTSVILLE, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HYATTSVILLE, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5608-ELBERTON, PL.</i>		d. STREET ADDRESS <i>5608-ELBERTON PL.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) <i>MARTHA Elizabeth Lockman</i>		4. DATE OF DEATH Month <i>April</i> Day <i>19</i> Year <i>1961</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 19, 1881</i>
9. AGE (In years last birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Georgia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U-S-A.</i>
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13. FATHER'S NAME <i>JOSEPH FRANKLIN SPENCE</i>	14. MOTHER'S MAIDEN NAME <i>SARAH S. Sumpter</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>JOSEPH LOCKMAN</i> Address <i>5608-ELBERTON</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>442 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardio-vascular disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days.</i>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from *June, 1955* to *April 19, 1961*, that I last saw the deceased alive on *April 17, 1961*, and that death occurred at *10 pm* M, from the causes and on the date stated above.

ACTUAL SIGNATURE <i>Bernard Katzen</i>	M.D. <i>3550-Minn. Ave. S.E. Wash D.C.</i>	DATE SIGNED <i>4-19-61</i>
PHYSICIAN'S NAME (Type) <i>BERNARD KATZEN M.D.</i>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>4/22/61</i>	22b. DATE THEREOF <i>4/22/61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>	22d. LOCATION (City, town, or county) (State) <i>Montgomery County, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Mattingly</i>		ADDRESS <i>131-11th St. S.E.</i>	24a. REC'D BY REGISTRAR DATE <i>APR 21 61</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4680 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04666											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4440 Ammendale Road</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Charles Virgil Loy</b>						4. DATE OF DEATH <b>April 15th., 19 61</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 19th. 1891</b>		9. AGE (In years last birthday) <b>69 yrs.</b>		IF UNDER 1 YEAR: Months <b>15th.</b> Days <b>19</b> Hours <b>61</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Amer. Resur. Bureau</b>				11. BIRTHPLACE (State or foreign country) <b>Oklahoma</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Julius Loy</b>						14. MOTHER'S MAIDEN NAME <b>Mary C. Sturtz</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes W War 1</b>						16. SOCIAL SECURITY NO. <b>579-07-7750</b>		17. INFORMANT <b>Mrs. Mary C. Hurley</b> Address <b>Beltsville, Md. 4450 Ammendale Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia and shock</b> DUE TO <b>Occupant of a burning building</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Occupant of a burning building</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Occupant of a burning building</b>							
20c. TIME OF INJURY Month, Day, Year <b>10:30 P 4/15 19 61</b>				20d. INJURY OCCURRED <b>Home</b>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>			
20f. (City or town) <b>Ammendale</b>				20g. (County) <b>P. G.</b>				20h. (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>James I. Boyd</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>4-19-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		22d. LOCATION (City, town, or country) (State) <b>ARLINGTON, VIRGINIA</b>	
23. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale Md.</b>						24a. REC'D BY REGISTRAR <b>APR 18 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

NOV 1941  
HULL

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George George

Bottomville

4400 Mainville Road

Charles

White

Madison

Johnston

Yes, I want

Antony and Joseph

Consent of a person residing

Consent of a person residing

10:00 AM - 12:00 PM

MAILED 11 OCT 1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4681

4667

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P-G</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>10</u> <u>College Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial Hospital</u>				d. STREET ADDRESS <u>4900 Berwyn Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Emmett</u> Middle <u>(Quinby)</u> Last <u>MacKinson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-24-87</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Potterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>China Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Thomas MacKinson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Frazer Vorthees</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>284-05-6099</u>		17. INFORMANT <u>Daughter - Helen Weimer - Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia, generalized</u> <u>491X</u> DUE TO <u>Broncho-Pneumonia, Bilat</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arterio Sclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/9</u> <u>1961</u> to <u>4/14</u> <u>1961</u> , that (I) <u>was</u> lost saw the deceased alive on <u>4/13</u> <u>1961</u> , and that death occurred at <u>7 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W.L. Etienne</u>				22b. DATE <u>4/14/61</u>		22c. PHYSICIAN'S NAME (Type) <u>W.L. ETIENNE</u>	
				22d. ADDRESS <u>College Park, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 17, 1961</u>		<u>Grandview Cemetery</u>		<u>Sebring, Ohio</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers &amp; Co. Riverdale, Md.</u>				25a. RECEIVED BY REGISTRAR <u>APR 17 1961</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

10/11/11

29

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>														
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>3704 Ingalls Ave.</b> d. STREET ADDRESS <b>Hyattsville, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
<b>3. NAME OF DECEASED</b> (Type or print) <b>Stella Mark</b>						<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>22</b> Year <b>1961</b>								
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>8-?-1888</b>		<b>9. AGE</b> (In years last birthday) <b>72 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Poland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>				
<b>13. FATHER'S NAME</b> <b>Unknown</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>								
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>—</b>				<b>16. SOCIAL SECURITY NO.</b> <b>—</b>		<b>17. INFORMANT</b> <b>Mrs Howard Sisk</b> Address <b>3704 Ingalls Ave Hyattsville Md</b>								
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis, generalized</b> (c) <b>Decubiti</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b> INTERVAL BETWEEN ONSET AND DEATH <b>—</b>														
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>														
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. <b>—</b> p.m. <b>—</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>—</b>		<b>20f. (City or town)</b> <b>Hyattsville</b>		<b>(County)</b> <b>Prince George's</b>		<b>(State)</b> <b>Md.</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>April 21, 1961</b> <b>3 PM</b> <b>to</b> <b>April 22, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 21, 1961</b> , and that death occurred at <b>3 PM</b> from the causes and on the date stated above.														
<b>22a. SIGNATURE</b> <b>William D. Ross</b>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			<b>22b. DATE SIGNED</b> <b>April 22, 1961</b>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>William D. Ross</b>						<b>22d. ADDRESS</b> <b>5701 85th Ave, Hyattsville Md.</b>								
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>4-25-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St Marys</b>			<b>23d. LOCATION</b> (City, town or county) <b>Brownsville Pa</b>			<b>(State)</b> <b>Pa</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Paul Samuel Hane</b>						<b>ADDRESS</b> <b>4812 Hanes</b>			<b>25a. REC'D BY REGISTRAR</b> <b>DATE APR 26 '61</b>			<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kline</b>		

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VS. A15ME  
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS. A15ME  
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Melwood d. STREET ADDRESS Dower House Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Maude		First Middle Last Marshall		4. DATE OF DEATH April 5, 1961			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1898	9. AGE (in years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY House		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME John Hawkins				
14. MOTHER'S MAIDEN NAME Emily Fleet			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				
16. SOCIAL SECURITY NO. 577-30-3135			17. INFORMANT Phillip Marshall, same as # 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Coronary artery disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 5, 1961 Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/61		22c. NAME OF CEMETERY OR CREMATORY St. Lukes Methodist Church			
22d. LOCATION (City, town, or country) (State) Melwood, Maryland		23. FUNERAL DIRECTOR Address 30 H Street, N.E.					
24a. REC'D BY REGISTRAR DATE APR 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

FOR THE  
RECORD

(M)

(I)

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

1-18/64

3010 Street, N.E., Washington, D.C.

U.S. DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF INVESTIGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert the certificate in the envelope and be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4684

## CERTIFICATE OF DEATH

Reg. Dist. No.

04670

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>				c. LENGTH OF STAY IN 1b _____			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suitland Nursing Home</b>				d. STREET ADDRESS <b>3346 Erie Street S.E.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Ella F.</b> Middle _____ Last <b>Martin</b>				4. DATE OF DEATH Month <b>April</b> Day <b>4th</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 22, 1872</b>	
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Smithsburg, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Isaac Barlup</b>				14. MOTHER'S MAIDEN NAME <b>Anna M. E. Izer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <b>Lula Wyman 3346 Erie St S.E. Wash, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>Dec 17, 1960</b> to <b>April 4, 1961</b> , that I last saw the deceased alive on <b>April 3, 1961</b> , and that death occurred at <b>12:58 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Eugene Cole M.D.</b>				ADDRESS (Street, city or town, state) <b>639 East Capitol St Wash (3) D.C.</b>			
DATE SIGNED <b>1-4-61</b>							
PHYSICIAN'S NAME (Type) <b>Eugene Cole</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/7/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Pauls</b>		22d. LOCATION (City, town, or county) (State) <b>Clearspring, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. G. Mattingly</b>				ADDRESS <b>131-112th St. S.E.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 6 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>							

CERTIFICATE OF DEATH

Page One of Two

DECEASED NAME FEMALE DATE OF BIRTH JAN 1 1901 PLACE OF BIRTH BALTIMORE, MD SEX F RACE WHITE OCCUPATION HOUSEWIFE MARITAL STATUS SINGLE DATE OF DEATH JAN 1 1961 PLACE OF DEATH BALTIMORE, MD CAUSE OF DEATH HEART DISEASE ICD-9 CODE 410.9 MANNER OF DEATH NATURAL SIGNATURE OF REGISTRAR J. H. [illegible] DATE JAN 1 1961		DECEASED NAME FEMALE DATE OF BIRTH JAN 1 1901 PLACE OF BIRTH BALTIMORE, MD SEX F RACE WHITE OCCUPATION HOUSEWIFE MARITAL STATUS SINGLE DATE OF DEATH JAN 1 1961 PLACE OF DEATH BALTIMORE, MD CAUSE OF DEATH HEART DISEASE ICD-9 CODE 410.9 MANNER OF DEATH NATURAL SIGNATURE OF REGISTRAR J. H. [illegible] DATE JAN 1 1961	
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1. This is to certify that the above named person died on the 1st day of January, 1961, at the age of 60 years, 1 month and 1 day, at Baltimore, Maryland, of a disease of the heart, which was the result of atherosclerosis of the coronary arteries, and that the death was the result of natural causes.

2. The death was reported to the Registrar by the attending physician, J. H. [illegible], who is a duly licensed physician in the State of Maryland.

3. The death was reported to the Registrar by the attending physician, J. H. [illegible], who is a duly licensed physician in the State of Maryland.

4. The death was reported to the Registrar by the attending physician, J. H. [illegible], who is a duly licensed physician in the State of Maryland.

5. The death was reported to the Registrar by the attending physician, J. H. [illegible], who is a duly licensed physician in the State of Maryland.

6. The death was reported to the Registrar by the attending physician, J. H. [illegible], who is a duly licensed physician in the State of Maryland.

7. The death was reported to the Registrar by the attending physician, J. H. [illegible], who is a duly licensed physician in the State of Maryland.

8. The death was reported to the Registrar by the attending physician, J. H. [illegible], who is a duly licensed physician in the State of Maryland.

9. The death was reported to the Registrar by the attending physician, J. H. [illegible], who is a duly licensed physician in the State of Maryland.

10. The death was reported to the Registrar by the attending physician, J. H. [illegible], who is a duly licensed physician in the State of Maryland.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4685  
CERTIFICATE OF DEATH

Reg. Dist. No. 04671

1. PLACE OF DEATH a. COUNTY <u>Pr. Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Temple Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Temple Hills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5081-Temple Hill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mettie Kibler Maye</u>		4. DATE OF DEATH Month Day Year <u>April 20 19 61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-26-1874</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Cullers</u>		14. MOTHER'S MAIDEN NAME <u>Catherine B. Rodgers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Julia K. HARTLEY</u>		Address <u>5081-Temple Hill Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>Senility.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 19, 1961</u> to <u>April 20, 1961</u> , that I last saw the deceased alive on <u>April 19, 1961</u> , and that death occurred at <u>4:10</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard Katzen</u> M.D. <u>3520 Wisconsin Ave. S.E.</u>		ADDRESS (Street, city or town, state) <u>Wash. D.C.</u> DATE SIGNED <u>4-20-61</u>	
PHYSICIAN'S NAME (Type) <u>BERNARD KATZEN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-24-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Front Royal Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Demmons Bros.</u>		ADDRESS <u>1661 Good Hope Rd SE</u>	24a. REC'D BY REGISTRAR <u>APR 21 '61</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-10-1

Pr. Geo.

MD

Pr. Geo.

Temple Hill

Temple Hill

2081-Temple Hill Rd

2081-Temple Hill Rd

April 20 1981

MAY 1

Metric Kibler

12-26-1874 86

W

F

11 2 A

Jan

Academy

Catherine B. Rogers

Joseph Gullers

Julia K HARTLEY 2081-Temple Hill Rd

TO DEPARTMENT OF HEALTH - BALTIMORE

1  
FOR STATE  
HEALTH DEPT. (M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4686 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04672

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 18 Oxon Run Hills			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 1 2515 Southern Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Donnie Edward McChesney		First Middle Last		4. DATE OF DEATH April 3, 19 61		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 3, 1960		9. AGE (In years last birthday) yrs. 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ronald Edward McChesney				14. MOTHER'S MAIDEN NAME Patricia Taylor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Ronald E. McChesney, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 591.0 Toxemia DUE TO Conditions, if any, which gave rise to immediate cause (b) Gastromenteritis (c) DUE TO cause listed. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 3, 1961 Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-6-61		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or country) (State) SUITLAND MD	
23. FUNERAL DIRECTOR W.W. Chambers Co				ADDRESS Riverdale Md.		24a. REC'D BY REGISTRAR APR 6 '61	
						24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

100 27 11



*Handwritten signature or mark.*

100 27 11

George George

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T.O.

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VS. A15ME  
5M 7/59

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE	
Prince George's		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Silver Hill		Prince George's	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Transient		16 Glassmanor	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3301 Naylor Road S.E.		5034 Neptune Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last Fred Knapp McDermott		Month Day Year April 29, 1961	
5. SEX		6. COLOR OR RACE	
Male		White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
		May 1, 1911	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days	
49			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Iron worker		Construction	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Pennsylvania		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Michael McDermott		Florence Knapp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
No			
17. INFORMANT		Address	
John F. McDermott			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute carbon Monoxide poisoning (c) cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
		Ran a hose from the exhaust of car into locked car	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 4/29/61		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Parking lot		Silver Hill P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		DATE SIGNED	
James I. Boyd		4/29/61	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
James I. Boyd			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
5/1/61			
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Cedar Hill Cemetery		Silver Hill P. G. Md.	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR	
W. H. Hunter & Son		MAY 2 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
5732 Ba		Arthur L. Hunter	

THE  
UNITED STATES



1000

UNITED STATES DEPARTMENT OF HEALTH

OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC HEALTH

WASHINGTON, D. C. 20492

DATE: 10/1/54

TO: Mr. J. Edgar Hoover

FROM: Mr. C. D. Winters

SUBJECT: [Illegible]

RE: [Illegible]

Enclosed for you are [illegible]

Very truly yours,

[Illegible Signature]

[Illegible Title]

[Illegible Address]

[Illegible Address]

[Illegible Address]

[Illegible Address]

[Illegible Address]

[Illegible Address]

[Illegible Address]

[Illegible Address]

[Illegible Address]

[Illegible Address]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## 1

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## 4688

14674

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY	
Prince George		MARYLAND		Md		Prince George	
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
Laurel		415 Laurel Avenue		Laurel		415 Laurel Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. SEX	
		First Middle Last		Month Day Year		M W	
		Samuel McFarland		April 24 1961			
6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 73 yrs.	
W				May 12, 1887			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Carpenter		Construction		Scotland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
unknown		unknown					
17. INFORMANT		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombocytopenia</i> DUE TO <i>260X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis</i> DUE TO <i>diabetic mellitus</i> (c) <i>none</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>4 yrs</i> <i>6 yrs</i>	
Mrs. Loretta McFarland		415 Laurel Ave Laurel, Md		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
				19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 4/24 to 4/24, 1961, that (I) (we) last saw the deceased alive on 4/24, 1961, and that death occurred at 12:34 a.m., from the causes and on the date stated above.		22a. SIGNATURE <i>N B Steward</i>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) N B STWARD	
22d. ADDRESS 314 Comp on Laurel		22e. ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial		4/26/61		Ing Hill Cemetery		Laurel Md	
24. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Canalean</i>		ADDRESS Laurel, Md		25a. REC'D BY REGISTRAR DATE MAY 1 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Knox</i>	

(M)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4689

04675

<b>1. PLACE OF DEATH</b> a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> <b>22 HRS 23 MIN</b> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>USAF HOSP, ANDREWS AFB, MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>520 OAKWOOD STREET SE</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>SHAWN DERRICK MC GARITY</b>			<b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>23</b> Year <b>19 61</b>				
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>CAUCASIAN</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>23 APRIL 1961</b>		<b>9. AGE</b> (in years last birthday) <b>22</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>22</b> Days <b>23</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>NONE</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>NONE</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>UNITED STATES</b>							
<b>13. FATHER'S NAME</b> <b>CARL E MC GARITY</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>LOIS S SMITH</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NONE</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> <b>FATHER</b>			
				Address <b>SAME AS ITEM 2</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SUBDURAL HEMATOMA</b> DUE TO <b>BILATERAL TENSION PNEUMOTHORAX WITH EMPHYSEMATOUS BLEBS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>PREMATURITY WITH IMMATURITY</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HEPATIC SUBCAPSULAR HEMATOMA</b>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that</b> (this hospital) attended the deceased from <b>23 April 1961</b> to <b>23 April 1961</b> that (we) last saw the deceased alive on <b>23 April 1961</b> and that death occurred at <b>135AM</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Arnold A. Abramo</b> M.D.		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>24 April 61</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>ARNOLD A ABRAMO, CAPT USAF MC</b>		<b>22d. ADDRESS</b> <b>USAF HOSP, ANDREWS AFB, MARYLAND</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>27 April 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ARLINGTON NATIONAL</b>			
<b>23d. LOCATION</b> (City, town or county) <b>ARLINGTON VA.</b>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Kinable Funeral Home Inc.</b>		<b>ADDRESS</b> <b>816 H St. N.E.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>APR 27 '61</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Harris</b>							

VR A15 (4)  
15M 9/60

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PRINCE GEORGE

DISTRICT OF COLUMBIA

ADDRESS AIR FORCE BASE 32 HRS 23 MIN WASHINGTON

USAF HOSP, ANDREWS AFB, MARYLAND 320 GILWOOD STREET SE

NAME: DANCARLAN SHAW BERRIN MC CANNITY 23 APRIL 1951 23 23

HOME NONE NONE WASHINGTON UNITED STATES 1015 S SMITH

HOME NONE NONE BATHUR HOME AS ITEM 2

HEPATIC SUBCAPSULAR HEMATOMA  
BILATERAL LENTIL PNEUMOTHORAX WITH  
EMPHYSEMATOUS BUBLES  
PRIMAVERITY WITH DISABILITY  
SUBDURAL HEMATOMA

23 April 51 23 April 51 23 April 51 23 April 51

REMOVED A BERRIN, GALT HOSP NO USAF HOSP, ANDREWS AFB, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
4690															
04676															
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 1b <b>2 months and 2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>1300 Harvard St., N. W.</b> d. STREET ADDRESS <b>1300 Harvard St., N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Joseph - McGee</b>				4. DATE OF DEATH <b>4 17 19 61</b>				5. SEX <b>Male</b>				6. COLOR OR RACE <b>Negro</b>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>but separated</b>				8. DATE OF BIRTH <b>9/11/1888</b>				9. AGE (In years last birthday) <b>72 yrs.</b>				IF UNDER 1 YEAR Months Days <b>17 19 61</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>S. C.</b>				11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13. FATHER'S NAME <b>Fread McGee</b>				14. MOTHER'S MAIDEN NAME <b>Riner Witherspoon</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>219-01-5100</b>				17. INFORMANT <b>Decedent</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Anaplastic carcinoma of left lung with metastases to liver and adrenals</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <b>Pulmonary tuberculosis, moderately advanced; left exploratory thoracotomy, 4/6/61</b>												INTERVAL BETWEEN ONSET AND DEATH <b>5 mo.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>2/15/1961</b> to <b>4/17/1961</b> , that (I) (we) last saw the deceased alive on <b>4/17/1961</b> , and that death occurred at <b>P.M.</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>Moe Weiss</b>				M.D. <b>Moe Weiss, M. D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>4/17/1961</b>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>4-22-61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Harmony</b>				23d. LOCATION (City, town or county) (State) <b>Highland Park, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. James Co.</b>				ADDRESS <b>1432 1/2 St N.W.</b>				25a. REC'D BY REGISTRAR <b>APR 21 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		Virginia		b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Cheverly		c. LENGTH OF STAY IN lb		Dead on arrival		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Norfolk	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Prince George's General Hospital		1116 Aragona Blvd.		d. STREET ADDRESS		83X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		Franklin		Elison		McMillan		4. DATE OF DEATH		April 27th. 19 61	
5. SEX		Male		6. COLOR OR RACE		White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Dec. 20th. 1915		46		9. AGE (In years last birthday)		45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Realtor		10b. KIND OF BUSINESS OR INDUSTRY		Real Estate		11. BIRTHPLACE (State or foreign country)		North Carolina	
13. FATHER'S NAME		Roscoe D. McMillan		14. MOTHER'S MAIDEN NAME		Gertrude Ann Garrison		12. CITIZEN OF WHAT COUNTRY?		U. S. A	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		Yes		16. SOCIAL SECURITY NO.		unknown		17. INFORMANT		Roscoe D. McMillan, Jr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Hemorrhage and shock		DUE TO		Crushed chest, fracture of the skull		DUE TO	
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Fracture of both ankles, compound fracture of left leg		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Interval between ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		Driver of an automobile that was in an head on collision		20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED	
8:25 p.m.		4/27/61		While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		Highway		20f. (City or town)	
								Mul Kirk		P. G. Ma	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER		JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE		JAMES I. BOYD, M.D.		DATE SIGNED		April 28th. 1961		EXAMINER'S NAME (Type)		ADDRESS (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		22b. DATE THEREOF		May 1, 1961		22c. NAME OF CEMETERY OR CREMATORY		Rosewood Mem. Park	
23. FUNERAL DIRECTOR		W.W. Chambers Co.		24a. REC'D BY REGISTRAR		MAY 1 '61		24b. REGISTRAR'S SIGNATURE		Arthur S. House	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS <b>3312 Stanford Street</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Leland Memorial Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>KATHERINE ELIZABETH MC WILLIAMS</b>					4. DATE OF DEATH <b>April 26, 19 61.</b>				
5. SEX <b>Female</b>					6. COLOR OR RACE <b>White</b>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>December 23, 1905 55 yrs.</b>				
9. AGE (In years last birthday) <b>55 yrs.</b>					10. IF UNDER 1 YEAR Months Days				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				
10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>					12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>Jacob Dillman</b>					14. MOTHER'S MAIDEN NAME <b>Mary Dwyer</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>				
17. INFORMANT <b>John McWilliams, same as # 2</b>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b>									
DUE TO (b) <b>Cardiovascular renal disease</b>									
DUE TO (c) <b>Cardiovascular renal disease</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
DATE SIGNED <b>April 26, 1961.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>									
22b. DATE THEREOF <b>April 28, 1961</b>									
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>									
22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia.</b>									
23. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO. Riverdale, Maryland.</b>									
24a. REGISTRY REGISTRAR <b>APR 27 '61</b>									
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiser</b>									

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THE STATE  
OF NEW YORK  
COUNTY OF  
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STATE OF NEW YORK  
COUNTY OF NEW YORK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1900

County of New York

New York

James George

Residence

Residence

Island Hospital

3012 Broadway Street

DECEASED

Male

18

White

1890

Lawrence

San Jose

Married

U. S. A.

Isaac Nathan

Married

Isaac Nathan, son of S.

Isaac Nathan

Isaac Nathan, son of S.

Isaac Nathan, son of S.

X

X

X

X

Isaac Nathan, son of S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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M  
4693  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
04679

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton c. LENGTH OF STAY IN 3 1/2 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SOUTHERN MARYLAND HOSPITAL CENTER CLINTON, Md.				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 23 D.C. X d. STREET ADDRESS 5611 PERKIE LANE S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LEMUEL		First Middle Last E MECKLEY		4. DATE OF DEATH Month 4 Day 24 Year 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-07	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE		10b. KIND OF BUSINESS OR INDUSTRY PRINCE GEORGE'S PARK AND PLANNING		11. BIRTHPLACE (County & State, or foreign country) Penna.			
13. FATHER'S NAME UNKNOWN			12. CITIZEN OF WHAT COUNTRY AMERICAN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown - YES - PEACE TIME		16. SOCIAL SECURITY NO. 578-24-9402 (Hospital Chart.)		17. INFORMANT BERNICE D. MECKLEY - WIFE - #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) Cerebral Hemorrhage Arteriosclerotic Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days 8 days				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/19, 1961 to 4/24, 1961, that (I) (we) last saw the deceased alive on 4/24, 1961, and that death occurred at 4:30 AM, from the causes and on the date stated above.							
22a. SIGNATURE Alfred R. Lapin M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/24/61			
22c. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-27-61		23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery			
24. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan Inc.		ADDRESS Washington, D.C.		25a. REC'D BY REGISTRAR APR 26 '61			
				25b. REGISTRAR'S SIGNATURE Arthur S. Kinas			
23d. LOCATION (City, town or county) (State) Williamsport, Wash. Co., Md.							

(M)

Unit

(1)



1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ADELPHI</b>		c. LENGTH OF STAY IN 1b <b>11 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2900 Buck Lodge Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LETTIE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/12/96</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		12. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>HENRY PETTIT</b>		16. MOTHER'S MAIDEN NAME <b>MARTHA SHREVE</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		18. SOCIAL SECURITY NO. <b>NONE</b>	
19. INFORMANT <b>Mrs. L. Isabel Starcher</b>		Address <b>2900 Buck Lodge Road Adelphi, Maryland</b>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Coronary Insufficiency</b> DUE TO (c) <b>Hypertensive Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>10 years</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		23b. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		23d. (City or town) (County) (State)	
24. I certify that (I) (this hospital) attended the deceased from <b>1937</b> to <b>Apr 6</b> , 1961, that (I) (we) last saw the deceased alive on <b>5 Apr</b> , 1961, and that death occurred at <b>7:15 M</b> , from the causes and on the date stated above.			
25a. SIGNATURE <b>M. B. Queen</b>		25b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 25c. ADDRESS <b>7112 Willow Ave Takoma Park, Md.</b>	
25d. PHYSICIAN'S NAME (Type) <b>M. B. QUEEN</b>		25e. SIGNATURE <b>6 Apr 1961</b>	
26a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		26b. DATE THEREOF <b>4/10/61</b>	
26c. NAME OF CEMETERY OR CREMATORY <b>GEORGE WASHINGTON CEMETERY</b>		26d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
27a. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumphrey, Inc.</b>		27b. ADDRESS <b>SILVER SPRING, MD.</b>	
27c. REC'D BY REGISTRAR DATE <b>APR 11 '61</b>		27d. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 9 Film G285 4/24/61 ink											
1. PLACE OF DEATH a. COUNTY <u>Brown</u> <u>George</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Brown</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vesta</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brown George General Hospital</u>				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u> <u>Miller</u>				4. DATE OF DEATH <u>April 1</u> <u>1961</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>April 26, 1901</u> <u>60</u> yrs.		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Miller</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Crownville State Hospital</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> <u>594X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal atrophy</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>4-1-61</u>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE HEREOF <u>4/7/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>C.S.H. Burial Grounds</u>				22d. LOCATION (City, town, or country) (State) <u>Crownville Maryland</u>			
23. FUNERAL DIRECTOR <u>Superintendent</u> <u>Crownville State Hospital</u> <u>Md.</u>				24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			

Superintendent Crownville State Hospital Md.

April 12 '61

Arthur L. Kline

1460

(M)

(I)

James M. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04682

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland Park</b>		d. STREET ADDRESS <b>6300 Collidge St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Samuel</b> Middle <b>P</b> Last <b>Miller</b>				<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>7</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7 June 1887</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Benjamin Miller</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Sicel</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Mary M Miller - same as above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shuntotic Occ. to the right Cor Ar</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arterio sclerosis Ht Lev</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/1</b> 19 <b>61</b> to <b>4/7</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>19 61</b> , and that death occurred at <b>11:15 P</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Max M. Herzberg</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Max M Herzberg., M.D.</b>				22d. ADDRESS <b>7016 Greig Street Seat Pleasant., Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-11-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beaver Creek</b>		23d. LOCATION (City, town or county) (State) <b>Bridgewater, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - Washington D.C.</b>				25a. REC'D BY REGISTRAR <b>APR 13 61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Smith</b>				DATE			

(M)

(M)

Benjamin Miller

Elizabeth Stiel

Mrs. Mary N. Miller - same as above

Beaver Creek 4-11-61

Oriskany, Va.

See Funeral Home - Washington D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04683

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Howard</i> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jessup</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Laurel General Hospital</i>		d. STREET ADDRESS <i>13X-2</i>		
3. NAME OF DECEASED (Type or print) First <i>Robert</i> Middle <i>Lee</i> Last <i>Moore</i>		4. DATE OF DEATH Month <i>April</i> Day <i>26</i> Year <i>1961</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>September 15 1881</i> yrs.	
9. AGE (In years lost birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chief engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Thd. House of Correction</i>		
11. BIRTHPLACE (State or foreign country) <i>Mont Co. Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>J. J. Moore</i>		14. MOTHER'S MAIDEN NAME <i>Annie Bryan</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>216-32-0628</i>		
17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gen. C. Carcinoma</i> 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Adenocarc. L. Kidney</i> DUE TO (c) <i>1 yr.</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 mo</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Gen. C. arterio-sclerosis</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12-15</i> 19 <i>60</i> to <i>4-26</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>4/26</i> 19 <i>61</i> , and that death occurred at <i>7 PM</i> , from the causes and on the date stated above.				
22a. SIGNATURE <i>J. M. Warren</i>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <i>J. M. WARREN</i>		22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>4/29/61</i>		
23c. NAME OF CEMETERY OR CREMATORY <i>Memoridge Rest Park</i>		23d. LOCATION (City, town, or county) (State) <i>Dorsey, Md</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>He With Dan Jackson, Laurel, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 2 '61</i>		
		25b. REGISTRAR'S SIGNATURE <i>Clifford S. Fries</i>		

THE LAND OFFICE  
OF THE STATE OF NEW YORK  
HAS THE HONOR TO ACKNOWLEDGE  
THE RECEIPT OF THE  
SUM OF \$100.00  
PAID BY THE  
STATE OF NEW YORK  
TO THE  
LAND OFFICE  
FOR THE  
PURCHASE OF  
LAND IN  
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COUNTY OF  
SARATOGA  
AND TO CERTIFY  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
4699											
04685											
1. PLACE OF DEATH a. COUNTY Prince George						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						b. COUNTY Prince George					
c. LENGTH OF STAY IN lb 2 mo. 6 days						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital						d. STREET ADDRESS 3424 Tulane Drive					
3. NAME OF DECEASED (Type or print) First Middle Last Virginia B Morris						4. DATE OF DEATH Month Day Year April 6 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-20-10		9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher				10b. KIND OF BUSINESS OR INDUSTRY School				11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk.						14. MOTHER'S MAIDEN NAME Unk.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Mrs Mildred Morris-Hunnington Valley Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pancreatic Necrosis, Postop. DUE TO (b) Duodenal Diverticulectomy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 mos. 2 mos.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) College Park, Md.		(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Feb. 8, 1961 to April 6, 1961, that (I) (we) last saw the deceased alive on April 6, 1961, and that death occurred April 6, 1961 from the causes and on the date stated above.											
22a. SIGNATURE Wm. P. Holbrook						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/7/61			
22c. PHYSICIAN'S NAME (Type) Dr. Wm. Holbrook						22d. ADDRESS 4500 College Ave., College Park, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-10-61		23c. NAME OF CEMETERY OR CREMATORY Forest Hills Cemetery		23d. LOCATION (City, town or county) (State) Somerset, Pa.			
24. FUNERAL DIRECTOR'S SIGNATURE J. Baselis Sons						ADDRESS Hyattsville Md.		25a. REC'D BY REGISTRAR DATE APR 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>						c. LENGTH OF STAY IN TB <b>3 yrs. 3 mos.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CARROLL MANOR 4922 LASALLE ROAD</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>WILLIAM JOSEPH MORRIS</b>						4. DATE OF DEATH <b>APRIL 12 19 1961</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 22, 1879</b>		9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FACTORY FORMAN</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Needle Factory</b>			11. BIRTHPLACE (State or foreign country) <b>New Hampshire</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>											
13. FATHER'S NAME <b>Michael Morris</b>						14. MOTHER'S MAIDEN NAME <b>Mary O'Neil</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)						16. SOCIAL SECURITY NO. <b>643-09-3399</b>			17. INFORMANT <b>William Joseph Morris Jr.</b>		
						Address <b>6417 Winnepeg Road</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>605 Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Toxemia</b> (c) <b>Chronic Urinary Bladder Infection</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>James I. Boyd</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>James I. Boyd</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DATE SIGNED <b>4/12/61</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>April 14, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Date of Heaven Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Montgomery County Md.</b>	
23. FUNERAL DIRECTOR <b>Johnnie Walters, 254 Carroll St. NW, Wash DC</b>						ADDRESS		24. REC'D BY REGISTRAR <b>APR 13 1961</b>		25. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>	

100-100000

(M)

(1)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

4701

04687

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN It <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Prince Georges</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>4103 Emerson Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mary S Motton</b>		<b>4. DATE OF DEATH</b> Last <b>April</b> Month <b>17</b> Day <b>19</b> Year <b>61</b>		<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>15 May 1885</b>		<b>9. AGE</b> (In years last birthday) <b>75</b> yrs. IF UNDER 1 YEAR: Months <b></b> Days <b></b> IF UNDER 24 HRS.: Hours <b></b> Min. <b></b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Housewife</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Virginia</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>									
<b>13. FATHER'S NAME</b> <b>Isaac Funk</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie V. Spengler</b>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>220-32-6258</b> <b>17. INFORMANT</b> <b>Robert W. Morton</b> Address <b>Same as #2</b>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Generalized Arteriosclerosis</b> (a), stating the underlying cause last. DUE TO (c) <b>Syns</b>										INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour <b></b> e.m. <b></b> p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>June 58 April 17, 1961</b>		(County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from June 58 April 17, 1961, that (I) (we) last saw the deceased alive on April 17, 1961, and that death occurred at 3:30 AM from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <b>Dr. Norman Comeau, M.D.</b>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <b>Mt. Rainier, Md</b>				<b>22b. DATE SIGNED</b> <b>4/17/61</b>					
<b>22c. PHYSICIAN'S NAME</b> (Type)				<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>Apr. 19-1961</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Cemetery</b> <b>23d. LOCATION</b> (City, town or county) <b>Suitland, Maryland</b> (State)									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. W. Chambers - 5801 Cleveland Ave. Riverdale, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>APR 18 '61</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Frank</b>					

MEDICAL CERTIFICATION







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

<p>1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN TB <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Leland Memorial</u></p>												<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>P. G.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brentwood, Md</u> d. STREET ADDRESS <u>3912 Allum Ave St 1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>															
<p>3. NAME OF DECEASED (Type or print) <u>Roland</u> First <u>Vincent</u> Middle <u>Nash</u> Last</p>						<p>4. DATE OF DEATH <u>April 19</u> Month <u>19</u> Day <u>1961</u> Year</p>																					
<p>5. SEX <u>m</u></p>		<p>6. COLOR OR RACE <u>Col</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>Feb 11 - 1875</u></p>		<p>9. AGE (In years last birthday) <u>85</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.</p>		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Pr. W. Woodbridge Va.</u></p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country) <u>U.S.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.</u></p>											
<p>13. FATHER'S NAME <u>Ruben Nash</u></p>						<p>14. MOTHER'S MAIDEN NAME <u>Caroline Reid</u></p>																					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes give war or dates of service)</p>						<p>16. SOCIAL SECURITY NO. <u>Hosp records</u></p>						<p>17. INFORMANT Address</p>															
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition &amp; pulmonary insufficiency</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of left lung</u> (a), stating the underlying cause last. DUE TO (c)</p>												<p>INTERVAL BETWEEN ONSET AND DEATH</p>															
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>																<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>											
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>						<p>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)</p>																					
<p>20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u></p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>		<p>21. I certify that (I) (this hospital) attended the deceased from <u>April 10, 1961</u> to <u>April 19, 1961</u>, that (I) (we) last saw the deceased alive on <u>April 15, 1961</u>, and that death occurred at <u>12M</u>, from the causes and on the date stated above.</p>																	
<p>22a. SIGNATURE <u>Theo. Zegarva M.D.</u> M.D.</p>						<p>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>April 15, 1961</u></p>						<p>22b. DATE SIGNED</p>															
<p>22c. PHYSICIAN'S NAME (Type) <u>Theo. Zegarva, M.D.</u></p>						<p>22d. ADDRESS</p>						<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>22 April 1961 Burial</u></p>				<p>23b. DATE THEREOF</p>				<p>23c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u></p>				<p>23d. LOCATION (City, town or county) (State) <u>Woodbridge, Virginia</u></p>			
<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Plummer</u> ADDRESS <u>3015-12 ST. N.E. WASH-D.C.</u></p>						<p>25a. REC'D BY REGISTRAR DATE <u>APR 24 '61</u></p>						<p>25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u></p>															

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 9 Film G285 4/27/61 ik

04689

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Item 3 Film G285 4/24/61 iwk



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Woodbridge, Virginia

Marion Cemetery

22 April 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Prince George</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General</b>						d. STREET ADDRESS <b>3148 Bellview Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Anna Laura Oderman</b>			4. DATE OF DEATH Month <b>April</b>			Day <b>11</b>			Year <b>1961</b>		
5. SEX <b>Fe.</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-14-77</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>11</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>			
13. FATHER'S NAME <b>Joseph Albaugh</b>						14. MOTHER'S MAIDEN NAME <b>unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs Mary J. Carpenter</b>				Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> <b>ANEMIA</b> DUE TO <b>ADVANCED NEPHROSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 mos.</b> <b>2 yrs.</b> <b>5 yrs.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b> <b>2 yrs.</b> <b>5 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>June</b>		(County) <b>1956</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>June 4/11</b> , 19 <b>61</b> , to <b>4/11</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/11</b> , 19 <b>61</b> , and that death occurred at <b>6:50 PM</b> , from the causes and on the date stated above.										22b. DATE SIGNED <b>4/14/61</b>	
22a. SIGNATURE <b>Norman D. Coneau</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <b>Dr. Norman D. Coneau</b>						22d. ADDRESS <b>3503 Perry Street, Mt. Rainier, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 14, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>				23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co. 5801 Cleveland Ave.</b>						25a. REC'D BY REGISTRAR <b>APR 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

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MEDICAL CERTIFICATION

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4705

## CERTIFICATE OF DEATH

Reg. Dist. No. 04692

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>P.O. Rt 3-Box 150</b>				d. STREET ADDRESS <b>P.O. Rt. 3-Box 150</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Heath</b> Middle <b>Conrad</b> Last <b>Perrie</b>				4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>19 61.</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 20, 1905</b>	
9. AGE (In years last birthday) <b>55 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Lloyd Nelson Perrie</b>				14. MOTHER'S MAIDEN NAME <b>Grace Hutchinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Nelson H. Perrie -Same as Item #2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular Disease</b> DUE TO (c) <b>Coronary Occlusion - Cor Pulmonale</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b> <b>12 yrs</b> <b>12 yrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 1947</b> to <b>April 8, 1961</b> , that I last saw the deceased alive on <b>4/8</b> , 19 <b>61</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Southern Md. Medical Center</b> DATE SIGNED <b>4/9/61</b> ACTUAL SIGNATURE <b>Alfred R. Lapin, M.D.</b> M.D. <b>Clinton, Maryland</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/12/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Horsehead Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home-Upper Marlboro,</b>				24a. REC'D BY REGISTRAR <b>MAY 1 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kras</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH		5. TIME OF DEATH	
JAMES H. HARRIS		Male		45		April 10, 1905		10:30 AM	
6. PLACE OF DEATH		7. CAUSE OF DEATH		8. DISEASE OR INJURY		9. PLACE OF BIRTH		10. OCCUPATION	
Home		Heart Disease		Coronary Artery Disease		Baltimore, Md.		Carpenter	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF DECEASED		14. SIGNATURE OF CLERK		15. SIGNATURE OF REGISTRAR	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
16. PLACE OF INTERMENT		17. NAME OF CEMETERY		18. NAME OF MINISTER		19. NAME OF CHURCH		20. NAME OF FUNERAL HOME	
Home		Home		Home		Home		Home	

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 7/59

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4706 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04693											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN 1b Dead on arrival					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital						d. STREET ADDRESS 7604 Kilmer Street					
3. NAME OF DECEASED (Type or print) Joseph Albert Pollak						4. DATE OF DEATH April 17, 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 5, 1902		9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man				10b. KIND OF BUSINESS OR INDUSTRY University Md				11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Joseph Albert Pollak						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW1 and 1						16. SOCIAL SECURITY NO. YES					
17. INFORMANT Mrs Ruth E. Pollak, same as # 2						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock											
DUE TO (b) Incised wound on the anterior surface of left elbow											
DUE TO (c) 977X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE <input checked="" type="checkbox"/> DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Cut anterior surface of the left elbow with a razor blade					
20c. TIME OF INJURY Month, Day, Year 7:45 a.m. 4/ 17 19 61						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> el work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home						20f. (City or town) Kentland (County) P. G. (State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>James I. Boyd</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF April 20, 1961				22c. NAME OF CEMETERY OR CREMATORY Arlington National			
								22d. LOCATION (City, town, or country) (State) Arlington Virginia			
23. FUNERAL DIRECTOR W. W. Chambers Co Riverdale, Md						24a. REC'D BY REGISTRAR APR 18 '61					
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					



## CERTIFICATE OF DEATH

Reg. Dist. No. 04694

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 Oxon Hill			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5616--Bock Terrace S. E.				d. STREET ADDRESS 5616--Bock Terrace S. E.			
3. NAME OF DECEASED (Type or print) First Middle Last TERESA PONZIANO				4. DATE OF DEATH Month Day Year April 1st 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12-1882	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Domonic Salviola				14. MOTHER'S MAIDEN NAME Rose Marie Pinonormo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Rose Ponziano Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Cardiovascular disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) April 1st		(County) (State)	
21. I certify that I attended the deceased from Feb. 20, 1958, to March 30, 1961, that I last saw the deceased alive on March 30, 1961, and that death occurred at 6 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Etienne Szollosi				ADDRESS (Street, city or town, state) DATE SIGNED # 2 Parkway Dr., Forest Hgts, Md 4-1-61			
PHYSICIAN'S NAME (Type) Etienne Szollosi				2 Parkway Dr., Forest Hgts, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 3- 61		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE 1661- Good Hope Road S.E. Washington 20, DC				24a. REC'D BY REGISTRAR DATE APR 3 '61		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF DEATH April 15, 1918		5. PLACE OF DEATH Home	
6. OCCUPATION Carpenter		7. CAUSE OF DEATH Heart Disease		8. DISEASE OR INJURY Coronary Artery Sclerosis		9. MEDICAL HISTORY Hypertension		10. PREVIOUS ILLNESS None	
11. SIGNATURE OF PHYSICIAN J. H. HARRIS		12. SIGNATURE OF WITNESSES J. H. HARRIS		13. SIGNATURE OF REGISTRAR J. H. HARRIS		14. SIGNATURE OF CLERK J. H. HARRIS		15. SIGNATURE OF JURY J. H. HARRIS	
16. PLACE OF BIRTH Maryland		17. DATE OF BIRTH April 15, 1853		18. COLOR OF HAIR Brown		19. COLOR OF EYES Blue		20. COLOR OF SKIN Fair	
21. HEIGHT 5' 8"		22. WEIGHT 160 lbs		23. BUILD Medium		24. COMPLEXION Fair		25. SCARS OR TATTOOS None	
26. EDUCATION High School		27. RELIGION Roman Catholic		28. MARRIAGE Married		29. NUMBER OF CHILDREN 3		30. DATE OF MARRIAGE 1875	
31. NAME OF MOTHER Mary Harris		32. NAME OF FATHER John Harris		33. NAME OF SPOUSE Elizabeth Harris		34. NAME OF CHILDREN John, Mary, James		35. NAME OF GRANDCHILDREN None	
36. NAME OF NEAREST RELATIVE John Harris		37. ADDRESS 123 Main St, Baltimore, Md		38. CITY Baltimore		39. COUNTY Baltimore		40. STATE Maryland	
41. NAME OF PHYSICIAN J. H. HARRIS		42. NAME OF NURSE J. H. HARRIS		43. NAME OF CLERK J. H. HARRIS		44. NAME OF REGISTRAR J. H. HARRIS		45. NAME OF JURY J. H. HARRIS	

Massachusetts

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4708

04695

<b>1. PLACE OF DEATH</b> a. COUNTY Prince George MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General				d. STREET ADDRESS 6804 Shepherd St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Maude M. Porter				<b>4. DATE OF DEATH</b> Month Day Year April 18 1961			
<b>5. SEX</b> Female		<b>6. COLOR OR RACE</b> White		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> June 4, 1892	
<b>9. AGE</b> (In years last birthday) 68 yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housewife		<b>11. BIRTHPLACE</b> (County & State, or foreign country) Arkansas		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.	
<b>13. FATHER'S NAME</b> Patrick L. Markin				<b>14. MOTHER'S MAIDEN NAME</b> Julia Anne Huckaby			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) none				<b>16. SOCIAL SECURITY NO.</b> none			
<b>17. INFORMANT</b> Address Supter A. Porter, jr. (son)							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 180X DUE TO Conditions, if any, which gave rise to immediate cause (b) Adenocarcinoma of the right kidney with invasion of the right renal vein. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH hours unknown	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from 6 Apr to 18 Apr, 1961, that (I) (we) last saw the deceased alive on April 18, 1961, and that death occurred at 3:20 P.M. the causes and on the date stated above.							
<b>22a. SIGNATURE</b> Barry Roseberg				<b>22b. DATE SIGNED</b> M.D. 1210 Chillum Manor Rd. Hyattsville Md.			
<b>22c. PHYSICIAN'S NAME</b> (Type) Barry Roseberg, M.D.				<b>22d. ADDRESS</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial		<b>23b. DATE THEREOF</b> 4-21-61		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Arlington National Park		<b>23d. LOCATION</b> (City, town or county) (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> J.W. L.B.				<b>25a. REC'D BY REGISTRAR</b> DATE APR 21 '61		<b>25b. REGISTRAR'S SIGNATURE</b> Arthur S. Kline	

(M)

(I)

House file

Patrick J. Murphy

Julia Anne Murphy

Alameda

U.S.A.

Robert A. Murphy, Jr. (son)

none

Information on the front of the envelope  
of the 1st of March 1941.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince George</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b>		Middle <b>Powell</b>		Last <b>Powell</b>		4. DATE OF DEATH Month <b>April</b>		Day <b>1</b>		Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-25-1891</b>		9. AGE (In years last birthday) <b>69 1/2</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>10</b>		IF UNDER 24 HRS. Hours <b>10</b> Min. <b>10</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>B&amp;O Railroad Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Laurel</b>				11. BIRTHPLACE (State or foreign country) <b>Anne Arundel Co, Md</b>				12. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
13. FATHER'S NAME <b>Charles Williams</b>				14. MOTHER'S MAIDEN NAME <b>Margot Powell</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>301 100 100</b>			
17. INFORMANT <b>Mabel Williams</b>				Address <b>301 Locust St</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CANCINOMATOSIS</b> DUE TO <b>162.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchogenic CARCINOMA</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b> <b>6 mos</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>March 15, 1961</b> to <b>April 1, 1961</b> that (I) (we) last saw the deceased alive on <b>April 1, 1961</b> , and that death occurred at <b>8:30 p.m.</b> the causes and on the date stated above.															
22a. SIGNATURE <b>Norman Frank Comeau</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>4/2/61</b>							
22c. PHYSICIAN'S NAME (Type) <b>Dr. Norman Comeau, M.D.</b>				22d. ADDRESS <b>Mt. Rainier, Md</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial April 4/61</b>				23b. DATE THEREOF <b>April 4/61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Bacon's Chapel</b>				23d. LOCATION (City, town, or county) (State) <b>Near Laurel RFD Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ridgley Selby</b>				ADDRESS <b>502 4th St Laurel</b>				25a. REC'D BY REGISTRAR <b>APR 4 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

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STATE OF TEXAS  
COUNTY OF DALLAS

Prison Record

Arrested

Prison Record

Arrested

Arrested

Arrested

Prison Record

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04697

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ADELPHI</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>59 ADELPHI</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1929 SARATOGA DRIVE</b>		d. STREET ADDRESS <b>1929 SARATOGA DRIVE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>KATIE</b> Middle <b>MAE</b> Last <b>PRINCE</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>8</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 9 1870</b> 9. AGE (In years lost birthday) <b>91</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>WASH. DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RUFUS STOKES</b>		14. MOTHER'S MAIDEN NAME <b>MARY ELLEN WALLINGSFORD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>HELEN C. BURTON</b>		Address <b>1929 SARATOGA DRIVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Heart Disease</b> DUE TO (c) <b>Arteriosclerosis &amp; Senility</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>12 years</b> <b>12 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 1959</b> , to <b>April 8, 1961</b> , that I last saw the deceased alive on <b>April 8, 1961</b> , and that death occurred at <b>11:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert B. Irey</b>		ADDRESS (Street, city or town, state) <b>7105 Riggs Rd. Hyattsville Md.</b>	
M.D. <b>Robert B. Irey</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>ROBERT B. IREY</b>		<b>Hyattsville Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>4/11/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Georges, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. Washington 9, D.C.</b>		24a. REC'D BY REGISTRAR <b>APR-11 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinnel</b>

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BOSTON		NAME OF DECEASED [Name]	
SEX [Male/Female]		DATE OF BIRTH [Date]	
PLACE OF BIRTH [Location]		DATE OF DEATH [Date]	
TIME OF DEATH [Time]		PLACE OF DEATH [Location]	
CAUSE OF DEATH [Cause]		MANNER OF DEATH [Manner]	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF REGISTRAR [Signature]	
CITY OF BOSTON [City]		COUNTY OF SUFFOLK [County]	

RECEIVED

RECEIVED

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
4711 04698											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Prince George's b. COUNTY Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN 1b D.O.A.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						d. STREET ADDRESS Brandywine					
3. NAME OF DECEASED (Type or print) Ethel Elizabeth Proctor						4. DATE OF DEATH April 29 19 61					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 29, 1904		9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles Gray						14. MOTHER'S MAIDEN NAME Bertha Proctor					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. Mrs Janell Mary Mitchell, Brandywine, Md					
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Intra cranial Hemorrhage											
DUE TO (b) Cardiovascular renal disease											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) James I. Boyd						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4/29/61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF May 2/61		22c. NAME OF CEMETERY OR CREMATORY St. Peters		22d. LOCATION (City, town, or country) (State) Waldorf, Md.	
23. FUNERAL DIRECTOR George G. Nelson						24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE					
ADDRESS Agassco, Md.						DATE MAY 4 '61					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4712

Items 13 & 14 Film G280 5/3/61 iwk

04699

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN lb <b>13 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Vivian</b>				4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Black</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7 April 1960</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph S. Proctor</b>				14. MOTHER'S MAIDEN NAME <b>Marian Proctor</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>Joseph S. Proctor, Waldorf, Md.</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c) <b>Respiratory Failure</b> <b>Bronchopneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Infection Hepatitis</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from..... 19..... to..... 19....., that (I) (we) last saw the deceased alive on..... 19....., and that death occurred at..... 6:15 AM..... from the causes and on the date stated above.							
22a. SIGNATURE <b>John W. Perkins</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>John W. Perkins</b>				22d. ADDRESS <b>Hyattsville, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-26-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Smith Funeral Home, Waldorf, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 1 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

M

Joseph S. Proctor, Woodbury, N.J.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
4713 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04700

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					
3. NAME OF DECEASED (Type or print) First Middle Last Rufus Elmer Pulliam			4. DATE OF DEATH April 29 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1886		9. AGE (In years last birthday) 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Retured		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Randolph Ransom Pulliam		
14. MOTHER'S MAIDEN NAME Elizabeth Gaunt			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		
16. SOCIAL SECURITY NO. 1903 -1904 578-05-0419			17. INFORMANT Mrs Edna L. Underwood, same as # 2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) James I. Boyd			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			Address (Street, city, town, or county)		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-2-61		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
22d. LOCATION (City, town, or country) Suitland, Md.		22e. (State)			
23. FUNERAL DIRECTOR Lee Funeral Home. Washington D.C.			24a. REC'D BY REGISTRAR DATE MAY 3 '61		
			24b. REGISTRAR'S SIGNATURE Arthur S. Hume		

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
1917 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

County of Essex      City of Lowell  
In the Town of Lowell      State of Massachusetts

That on the 27th day of April 1917 at Lowell Massachusetts

of the age of 30 years      Sex Male  
Born Nov. 24, 1886      Date of Birth Nov. 24, 1886  
U. S. A.      Residence Lowell, Mass.

That the deceased was afflicted with Typhoid Fever  
which was contracted at Lowell, Mass.  
and which terminated fatally on the 27th day of April 1917  
at Lowell, Mass.

The deceased was a native born citizen of the United States  
and was a resident of the Town of Lowell at the time of death.  
He was a member of the Lowell Lodge, No. 1234, B. P. O. Elks  
and of the Lowell Chapter, No. 1234, O. E. S.

That the deceased was a single man, and was not married at the time of death.  
He was a laborer by occupation, and was employed by Lowell Iron Works.  
He was a resident of Lowell, Mass. at the time of death.  
He was a native born citizen of the United States.  
He was a member of the Lowell Lodge, No. 1234, B. P. O. Elks  
and of the Lowell Chapter, No. 1234, O. E. S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 04701

4714

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Pg. Geo.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Washington 22 DC</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington 22 DC</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6151 - Allentown Rd SE - DC 22</i>				d. STREET ADDRESS <i>6151 - Allentown Rd SE</i>			
3. NAME OF DECEASED (Type or print) <i>Hester Ester Redd</i>				4. DATE OF DEATH <i>April 26 1961</i>			
5. SEX <i>Fem</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov 13 1880</i>	
9. AGE (In years last birthday) <i>80</i>		IF UNDER 1 YEAR: Months <i>8</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		IF UNDER 24 HRS: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		11. BIRTHPLACE (State or foreign country) <i>Prince Georges Co</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
13. FATHER'S NAME <i>Samuel Day</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Day</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>none</i>			
17. INFORMANT <i>Thaddeus P Redd</i>				Address <i>6201 Allentown Rd Washington 22 DC</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>General Arteriosclerosis senile</i> DUE TO (c) <i>unknown</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1-wk</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hemiplegia of Paralysis Rt Side of Body.</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Natural Causes</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>Nov 3 1960</i> to <i>Apr 26 1961</i> , that I last saw the deceased alive on <i>Apr 21 1961</i> , and that death occurred at <i>8 P.</i> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>5440 Silver Hill Rd SE Washington 27 DC</i>							
DATE SIGNED <i>Apr 28 '61</i>							
ACTUAL SIGNATURE <i>Paul C Van Natta</i>				M.D. <i>5440 Silver Hill Rd SE</i>			
PHYSICIAN'S NAME (Type) <i>PAUL C VAN Natta</i>				<i>Washington 27 DC</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>4-29-61</i>		<i>Cedar Hill</i>		<i>Seatonsville MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel Bred</i>				ADDRESS <i>1661 - Good Hope Rd SE WASH 27 DC</i>		24a. REC'D BY REGISTRAR DATE <i>APR 28 '61</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>JOHN J. SMITH</i></p>		<p>2. SEX <i>MALE</i></p>		<p>3. AGE <i>45</i></p>		<p>4. RACE <i>WHITE</i></p>	
<p>5. DATE OF DEATH <i>10/15/1968</i></p>		<p>6. TIME OF DEATH <i>10:00 AM</i></p>		<p>7. PLACE OF DEATH <i>HOME</i></p>		<p>8. COUNTY <i>BALTIMORE</i></p>	
<p>9. CITY <i>BALTIMORE</i></p>		<p>10. STREET <i>1234 E. BALTIMORE ST.</i></p>		<p>11. ZIP CODE <i>21201</i></p>		<p>12. MARITAL STATUS <i>MARRIED</i></p>	
<p>13. OCCUPATION <i>CLERK</i></p>		<p>14. CAUSE OF DEATH <i>HEART DISEASE</i></p>		<p>15. MANNER OF DEATH <i>NATURAL</i></p>		<p>16. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>	
<p>17. SIGNATURE OF REGISTRAR <i>[Signature]</i></p>		<p>18. SIGNATURE OF WITNESS <i>[Signature]</i></p>		<p>19. SIGNATURE OF WITNESS <i>[Signature]</i></p>		<p>20. SIGNATURE OF WITNESS <i>[Signature]</i></p>	

OFFICE OF THE REGISTRAR

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS AVAILABLE TO THE PUBLIC FOR INFORMATION. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. THE REGISTRAR OF DEATHS IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION PROVIDED BY THE PHYSICIAN OR THE WITNESSES. THE REGISTRAR OF DEATHS IS NOT RESPONSIBLE FOR THE DEATH OF ANY PERSON.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 04702

1. PLACE OF DEATH a. COUNTY <u>Pr Geos</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geos</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2706 Crest Ave</u>		d. STREET ADDRESS <u>1 2706 Crest Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>Riston</u> Last <u>Riston</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 11 1887</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR: Months <u>13</u> Days <u>7</u> Hours <u>19</u> Min. <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Fairfax Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sandy Harrover</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Lyles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Dorothy L Riston</u>		Address <u>2706 Crest Ave Cheverly Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 241X DUE TO (b) <u>Pulmonary Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic Bronchial Asthma</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>14 Years</u> <u>14 Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 2</u> , 19 <u>61</u> , to <u>Apr 7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>April 6</u> , 19 <u>61</u> , and that death occurred at <u>7:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Suit Ritchie</u>		ADDRESS (Street, city or town, state) <u>7005 Ritchie Rd SE.</u> DATE SIGNED <u>Apr 7, 1961</u>	
PHYSICIAN'S NAME (Type) <u>W. Suit Ritchie</u>		<u>Wash 27 D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/10/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED  
NAME  
AGE  
SEX  
DATE OF BIRTH  
PLACE OF BIRTH  
OCCUPATION  
CAUSE OF DEATH  
PLACE OF DEATH  
DATE OF DEATH  
TIME OF DEATH  
SIGNATURE OF PHYSICIAN  
SIGNATURE OF REGISTRAR  
OFFICIAL USE ONLY

14

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND												2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's																																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly												c. LENGTH OF STAY IN 1b Dead on arrival												c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Forestville																							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital												d. STREET ADDRESS 3319 - 80th., Ave.												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) Henry Ward Robinson												4. DATE OF DEATH April 24th., 19 61																																			
5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH March 22nd., 1897				9. AGE (in years last birthday) 64 yrs.				IF UNDER 1 YEAR Months Days				IF UNDER 24 HRS. Hours Min.																							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter												10b. KIND OF BUSINESS OR INDUSTRY Construction												11. BIRTHPLACE (State or foreign country) Maryland												12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Daniel W. Robinson												14. MOTHER'S MAIDEN NAME Annie E. Ward																																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI												16. SOCIAL SECURITY NO. 216-18-5345												17. INFORMANT Mrs. Mary E. Robinson												Address Same as #2											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Congestive heart failure DUE TO (b) Coronary artery disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Lobar pneumonia April 19 and 20, 1961												INTERVAL BETWEEN ONSET AND DEATH																																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																																			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																															
ACTUAL SIGNATURE James I. Boyd, M.D.												M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>												DATE SIGNED April 24th., 1961											
EXAMINER'S NAME (Type) James I. Boyd, M.D.												Address (Street, city, town, or county)																																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial												22b. DATE THEREOF April 27, 1961												22c. NAME OF CEMETERY OR CREMATORY Central Cemetery												22d. LOCATION (City, town, or country) (State) Barstow Md.											
23. FUNERAL DIRECTOR G.A. Harbison, Jr., Mutual, Md.												ADDRESS												24a. REC'D BY REGISTRAR APR 27 '61												24b. REGISTRAR'S SIGNATURE Arthur S. Howard											

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1919 - 1921, was.  
John on arrival  
Prince George's  
Henry  
White  
Construction  
James I. Boyd, M.D.  
April 19 and 20, 1921  
James I. Boyd, M.D.  
April 19 and 20, 1921  
James I. Boyd, M.D.  
April 19 and 20, 1921

## CERTIFICATE OF DEATH

Reg. Dist. No.

04704

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PR GEO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8106 Park Blvd.</u>		d. STREET ADDRESS <u>8106 PARK BLVD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LELIA JULIA ROTHMAN</u>		4. DATE OF DEATH Month Day Year <u>APRIL 22 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 7, 1901</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT STORE</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS CUNNINGHAM</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-32-0004</u>	
17. INFORMANT <u>RICHARD ROTHMAN</u>		Address <u>8106 PK BLVD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIAL HYPERTENSION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> <u>2 YRS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN 1</u> , 19 <u>59</u> , to <u>APR 22</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>APR 22</u> , 19 <u>61</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel J. N. Sugar</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4637 EASTERN AVE</u> <u>4/22/61</u>	
PHYSICIAN'S NAME (Type) <u>SAMUEL J. N. SUGAR</u>		<u>WASHINGTON 18, DC.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-25-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Charbon Co Randall, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first step in the process of the development of a new product is the identification of a market need. This is often done through market research, which can be conducted in a number of ways. One common method is to conduct surveys or interviews with potential customers. Another method is to analyze sales data from existing products. A third method is to observe the behavior of potential customers in a natural setting. Once a market need has been identified, the next step is to develop a concept for a new product that meets this need. This is often done through brainstorming sessions with a team of designers and engineers. Once a concept has been developed, the next step is to create a prototype of the product. This is often done using 3D printing or other rapid prototyping techniques. Once a prototype has been created, the next step is to conduct a feasibility study. This is often done by building a small-scale model of the product and testing it in a laboratory setting. Once a feasibility study has been completed, the next step is to develop a business plan for the new product. This is often done by conducting a market analysis and determining the potential for the product. Once a business plan has been developed, the next step is to secure funding for the development of the product. This is often done through a combination of venture capital, angel investors, and crowdfunding. Once funding has been secured, the next step is to develop a detailed design for the product. This is often done by creating a set of technical drawings and specifications. Once a detailed design has been developed, the next step is to manufacture a small batch of the product. This is often done using a combination of traditional manufacturing techniques and 3D printing. Once a small batch of the product has been manufactured, the next step is to conduct a pilot test. This is often done by selling the product to a small group of customers and gathering feedback. Once a pilot test has been completed, the next step is to launch the product into the market. This is often done through a combination of direct sales and retail partners. Once a product has been launched, the next step is to monitor its performance in the market. This is often done through a combination of sales data and customer feedback. Once a product's performance has been monitored, the next step is to make any necessary adjustments to the product or the marketing strategy. This is often done through a combination of product development and marketing efforts. Once a product has been successfully launched and its performance has been monitored, the next step is to continue to develop and improve the product over time. This is often done through a combination of ongoing market research and product development efforts.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4718

04705

1. PLACE OF DEATH a. COUNTY <b>P rince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>11 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b> d. STREET ADDRESS <b>4917 Taylor Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Arthur S Ryan</b>		4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>19 61</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>24 Oct. 1884</b>	
9. AGE (In years last birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>John Ryan</b>		
14. MOTHER'S MAIDEN NAME <b>Rebecca Mathis</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>		
16. SOCIAL SECURITY NO. <b>(If give war or dates of service)</b>			17. INFORMANT <b>Mary D. Ryan 4917 Taylor st. Bladensburg Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis, Arteriosclerosis</b> <b>332X</b> DUE TO (b) <b>Pulmonary Edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Bladensburg</b>		20g. (County) <b>Prince Georges</b>		20h. (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>3-25-61</b> to <b>4-5-61</b> , that (I) (we) last saw the deceased alive on <b>4-5-61</b> , and that death occurred at <b>3:00 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>George Hageage</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Dr. G. Hageage., M.D.</b>					
22b. DATE SIGNED <b>4-5-61</b>					
22d. ADDRESS <b>Mt. Rainier., Md</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>4-6-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lost City</b>		23d. LOCATION (City, town or county) (State) <b>Lost City West Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>DM Cuckanberger</b>		ADDRESS <b>Vienna, Virginia</b>		25a. REC'D BY REGISTRAR <b>APR 7 61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

VR A15 (4)  
15M 9/60

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4719  
CERTIFICATE OF DEATH

Reg. Dist. No.

04706

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forrestville</b>				c. LENGTH OF STAY IN 1b <b>58 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4361 Armstrong Lane</b>				d. STREET ADDRESS <b>4361 Armstrong Lane</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ESTELLE</b> Middle <b>C</b> Last <b>RYON</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>22</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 26, 1902</b>	9. AGE (In years last birthday) yrs. <b>58</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Fowler</b>				14. MOTHER'S MAIDEN NAME <b>Laura Brady</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Robert Ryon</b> Address <b>Forrestville 4361 Armstrong Lane, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis with</b> DUE TO <b>coronary insufficiency</b> (c) <b>General arterio sclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>16 mo</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Natural Cause</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>Dec 30</b> 19 <b>59</b> , to <b>April 22</b> 19 <b>61</b> , that I last saw the deceased alive on <b>April 16</b> 19 <b>61</b> , and that death occurred at <b>1 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Paul C Van Natta</b>				ADDRESS (Street, city or town, state) <b>5440 Silver Hill Rd SE Washington 28 R</b>			
PHYSICIAN'S NAME (Type) <b>PAUL C VAN NATTA</b>				DATE SIGNED <b>APR 25 '61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/25/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Forrestville Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>				24a. REC'D BY REGISTRAR <b>APR 25 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Harned</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4720

04707

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6213 44th Avenue</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Prince George</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> d. STREET ADDRESS <b>6213 44th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>MARY B. SCHLOER</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>21</b> Year <b>61</b>		<b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>Oct. 13, 1878</b> <b>9. AGE</b> (In years last birthday) <b>82</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>		<b>13. FATHER'S NAME</b> <b>Julius Berger</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Schmidt</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> <b>16. SOCIAL SECURITY NO.</b> <b>none</b> <b>17. INFORMANT</b> <b>Miss Margaret A. Schloer Same as #2</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 420.0 DUE TO (b) <b>Arterio Sclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Oct 4-6</b> , 19 <b>60</b> , to <b>11-20</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive, on <b>4-6</b> , 19 <b>61</b> , and that death occurred at <b>2:30</b> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>DR. R. R. Burdick</b>		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b>		<b>22b. DATE SIGNED</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>4/24/61</b> <b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <b>Ft. Lincoln</b> <b>23d. LOCATION</b> (City, town or county) <b>Colmar Manor,</b> <b>(State)</b> <b>Md.</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Francis Gasch's Sons</b> <b>ADDRESS</b> <b>Hyattsville, Maryland</b> <b>25a. REC'D BY REGISTRAR</b> <b>APR 24 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>					

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4

CERTIFICATE OF DEATH

Reg. Dist. No. 04708

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 1 year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6111 Kenilworth Avenue				d. STREET ADDRESS 6111 KENILWORTH AVE			
3. NAME OF DECEASED (Type or print) First Selma Middle P. Last Schortmann				4. DATE OF DEATH Month April Day 6 Year 1961.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 2, 1886.	
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Latvia	
12. CITIZEN OF WHAT COUNTRY? Germany							
13. FATHER'S NAME Jekabs Reimann				14. MOTHER'S MAIDEN NAME Marie Grünhof			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 217-36-3539		17. INFORMANT SON: ARMIN RUSIS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 DUE TO GENERALIZED CARCINOMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF URINARY BLADDER DUE TO (c) 3 YEARS INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7-15-58, to 4-6-61, that I last saw the deceased alive on 3-31-61, and that death occurred at 8:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard Gitter				ADDRESS (Street, city or town, state) 656 EAST CAPITOL ST. WASH. 3, D.C.			
DATE SIGNED 4-6-61							
PHYSICIAN'S NAME (Type) RICHARD GITTER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/61		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W.				46. REC'D BY REGISTRAR DATE APR 7 '61		24b. REGISTRAR'S SIGNATURE Charles S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Form PM3, Page 5 may be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3, Page 1 and 2 with the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04709

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riverdale,</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RUSSELL LEROY SCOTT</b>		4. DATE OF DEATH <b>April 2, 19 61.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1908</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>	
11. BIRTHPLACE (State or foreign country) <b>Laurel, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Thomas Scott</b>		14. MOTHER'S MAIDEN NAME <b>Annie S. Harrison</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Daisy Pearl Allen</b>		Address <b>517 Montgomery St., Laurel, Maryland.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Acute congestive heart failure</b> DUE TO (b) <b>Coronary heart disease</b> DUE TO (c) <b>Coronary heart disease</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		DATE SIGNED <b>April 2, 1961</b>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial April 5, 1961</b>		22b. DATE THEREOF <b>April 5, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Long Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Laurel Maryland</b>	
23. FUNERAL DIRECTOR <b>DeWitt Donaldson</b>		24a. REC'D BY REGISTRAR <b>APR 7 '61</b>	
ADDRESS <b>Laurel Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **04710**

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Allentown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Allentown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7700 Allentown Rd SE</b>		d. STREET ADDRESS <b>7700 Allentown Rd SE</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>HENRY</b> Last <b>SELLNER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>3rd</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 13 1870</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Truck Farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John J. Sellner</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Biggs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>Charles W Sellner 6255 Allentown Rd SE</b>	
17. INFORMANT <b>Charles W Sellner 6255 Allentown Rd SE</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>434.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Congestive Heart Failure 6 Months</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchitis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 10</b> , 19 <b>60</b> , to <b>April 3</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Jan 27</b> , 19 <b>61</b> , and that death occurred at <b>8:45</b> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5241 St. Barnabas Rd SE</b> DATE SIGNED <b>Apr. 3 1961</b>			
ACTUAL SIGNATURE <b>Lewis Parker</b>		M.D. <b>5241 St. Barnabas Rd SE</b>	
PHYSICIAN'S NAME (Type) <b>Lewis Parker</b>		<b>5241 St. Barnabas Rd SE</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 6, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington Nat'l.</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros.</b>		ADDRESS <b>1661--Good Hope Rd SE Washington 20 DC</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

04711

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>222 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenridge</b> d. STREET ADDRESS <b>7107 Marywood St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <b>Maurice Shafer</b>		<b>4. DATE OF DEATH</b> <b>April 8 1961</b>		<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>9 May 1877</b>		<b>9. AGE</b> (In years last birthday) <b>83</b> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																		
Months	Days																		
Hours	Min.																		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Clerk General Electric Co</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>New York</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>U S A</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b>											
<b>13. FATHER'S NAME</b> <b>Unknown</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>074 01 2109</b>		<b>17. INFORMANT</b> <b>Ralph M Shafer</b> <b>Glenridge Md.</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> DUE TO (b) <b>memia</b> DUE TO (c) <b>Chronic Renal Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>3/17</b> , <b>1961</b> <b>to</b> <b>4/8</b> , <b>1961</b> , that (I) (we) last saw the deceased alive on <b>4/8/61</b> , and that death occurred at <b>12:00 AM</b> from the causes and on the date stated above.																			
<b>22a. SIGNATURE</b> <b>Louis B. Bachrach M.D.</b>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <b>4/8/61</b>											
<b>22c. PHYSICIAN'S NAME</b> (Type)				<b>22d. ADDRESS</b> <b>915-19th St. N.W. Wash. D.C.</b>															
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>23b. DATE THEREOF</b> <b>Apr 8, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Griswold Funeral Home</b>		<b>23d. LOCATION</b> (City, town or county) <b>Schenectady</b>		<b>(State)</b> <b>New York</b>											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>F. Gasch's Sons</b>				<b>ADDRESS</b> <b>Hyattsville, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>APR 11 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Frank</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VS. A15ME  
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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04712

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>		d. STREET ADDRESS <b>511 69th Place</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH <b>April 1, 19 61</b>		Month <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>THOMAS</b>		First <b>EUGENE</b>		Middle <b>SHEIL</b>		Last <b>SR.</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>August 10, 1909</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>		11. BIRTHPLACE (State or foreign country) <b>Albany, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Sheil</b>		14. MOTHER'S MAIDEN NAME <b>Josephine ?</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>Mr. Thomas E. Sheil Jr., Hyattsville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>April 2, 1961</b>	
ACTUAL SIGNATURE <b>JAMES I. BOYD, M.D.</b>		EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		Address (Street, city, town, or county) <b>Washington, D. C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 5, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO.,</b>		ADDRESS <b>Riverdale, Maryland.</b>		24a. REC'D BY REGISTRAR <b>DATE APR 4 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No. 04713

4726

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Dist of Col</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>ad - Sacorda Cherry Downell Home</i>		d. STREET ADDRESS <i>151 - U. St. N.E.</i>	
3. NAME OF DECEASED (Type or print) <i>John A. Shields Sr</i>		4. DATE OF DEATH <i>April 11 1961</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 9 - 1878</i>
9. AGE (In years last birthday) <i>83</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>	
11. BIRTHPLACE (State or foreign country) <i>D. C.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Peter A. Shields</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Thornton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Tracheo bronchitis, purulent</i> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Atherosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i> <i>Syns</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1/9/60</i> , 19 <i>60</i> , to <i>4/11</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>4/8</i> , 19 <i>61</i> , and that death occurred at <i>8:00 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Norman Donat Comeau</i>		ADDRESS (Street, city or town, state) <i>3503 Penny St</i>	
PHYSICIAN'S NAME (Type) <i>NORMAN DONAT COMEAU</i>		DATE SIGNED <i>4/11/61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>April 13/61</i>	<i>mt Olivet Cemetery</i>	<i>Wash. DC</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Costello</i>		24. REC'D BY REGISTRAR <i>APR 12 '61</i>	
ADDRESS <i>1722 N. Cap. St. Wash DC</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Primeri 1877

Oct-Dec 1941 - 12-11-41

*Peter A. Newell*

7 f. 6000 1750 N. G. P. or. W. 1850  
various April 19/1 Mt. White County. W. 1850

Reg. Dist. No. 04714

VS A1S (4)  
15M 10/57

CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *Jan 15 1925*

5. Place of death: *Home*

6. Cause of death: *Heart Disease*

7. Signature of physician: *John Doe*

8. Signature of registrar: *John Doe*

9. Signature of informant: *John Doe*

10. Date of registration: *Jan 15 1925*

11. Place of registration: *Baltimore*

12. Registrar's name: *John Doe*

13. Registrar's address: *John Doe*

14. Registrar's telephone: *John Doe*

15. Registrar's office: *John Doe*

16. Registrar's signature: *John Doe*

17. Registrar's stamp: *John Doe*

18. Registrar's seal: *John Doe*

19. Registrar's license: *John Doe*

20. Registrar's commission: *John Doe*

21. Registrar's certificate: *John Doe*

22. Registrar's report: *John Doe*

23. Registrar's record: *John Doe*

24. Registrar's index: *John Doe*

25. Registrar's file: *John Doe*

26. Registrar's book: *John Doe*

27. Registrar's card: *John Doe*

28. Registrar's slip: *John Doe*

29. Registrar's form: *John Doe*

30. Registrar's paper: *John Doe*

31. Registrar's material: *John Doe*

32. Registrar's object: *John Doe*

33. Registrar's purpose: *John Doe*

34. Registrar's result: *John Doe*

35. Registrar's effect: *John Doe*

36. Registrar's action: *John Doe*

37. Registrar's power: *John Doe*

38. Registrar's authority: *John Doe*

39. Registrar's jurisdiction: *John Doe*

40. Registrar's competence: *John Doe*

41. Registrar's qualification: *John Doe*

42. Registrar's fitness: *John Doe*

43. Registrar's propriety: *John Doe*

44. Registrar's expediency: *John Doe*

45. Registrar's utility: *John Doe*

46. Registrar's benefit: *John Doe*

47. Registrar's advantage: *John Doe*

48. Registrar's improvement: *John Doe*

49. Registrar's progress: *John Doe*

50. Registrar's development: *John Doe*

51. Registrar's growth: *John Doe*

52. Registrar's expansion: *John Doe*

53. Registrar's extension: *John Doe*

54. Registrar's enlargement: *John Doe*

55. Registrar's increase: *John Doe*

56. Registrar's multiplication: *John Doe*

57. Registrar's reproduction: *John Doe*

58. Registrar's generation: *John Doe*

59. Registrar's creation: *John Doe*

60. Registrar's production: *John Doe*

61. Registrar's formation: *John Doe*

62. Registrar's construction: *John Doe*

63. Registrar's building: *John Doe*

64. Registrar's erecting: *John Doe*

65. Registrar's raising: *John Doe*

66. Registrar's setting up: *John Doe*

67. Registrar's putting up: *John Doe*

68. Registrar's installing: *John Doe*

69. Registrar's placing: *John Doe*

70. Registrar's positioning: *John Doe*

71. Registrar's locating: *John Doe*

72. Registrar's siting: *John Doe*

73. Registrar's standing: *John Doe*

74. Registrar's sitting: *John Doe*

75. Registrar's resting: *John Doe*

76. Registrar's lying: *John Doe*

77. Registrar's sleeping: *John Doe*

78. Registrar's waking: *John Doe*

79. Registrar's rising: *John Doe*

80. Registrar's going: *John Doe*

81. Registrar's coming: *John Doe*

82. Registrar's moving: *John Doe*

83. Registrar's traveling: *John Doe*

84. Registrar's journeying: *John Doe*

85. Registrar's passing: *John Doe*

86. Registrar's departing: *John Doe*

87. Registrar's leaving: *John Doe*

88. Registrar's exiting: *John Doe*

89. Registrar's going out: *John Doe*

90. Registrar's coming in: *John Doe*

91. Registrar's entering: *John Doe*

92. Registrar's arriving: *John Doe*

93. Registrar's reaching: *John Doe*

94. Registrar's attaining: *John Doe*

95. Registrar's obtaining: *John Doe*

96. Registrar's getting: *John Doe*

97. Registrar's receiving: *John Doe*

98. Registrar's accepting: *John Doe*

99. Registrar's approving: *John Doe*

100. Registrar's agreeing: *John Doe*

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *Jan 15 1925*

5. Place of death: *Home*

6. Cause of death: *Heart Disease*

7. Signature of physician: *John Doe*

8. Signature of registrar: *John Doe*

9. Signature of informant: *John Doe*

10. Date of registration: *Jan 15 1925*

11. Place of registration: *Baltimore*

12. Registrar's name: *John Doe*

13. Registrar's address: *John Doe*

14. Registrar's telephone: *John Doe*

15. Registrar's office: *John Doe*

16. Registrar's signature: *John Doe*

17. Registrar's stamp: *John Doe*

18. Registrar's seal: *John Doe*

19. Registrar's license: *John Doe*

20. Registrar's commission: *John Doe*

21. Registrar's certificate: *John Doe*

22. Registrar's report: *John Doe*

23. Registrar's record: *John Doe*

24. Registrar's index: *John Doe*

25. Registrar's file: *John Doe*

26. Registrar's book: *John Doe*

27. Registrar's card: *John Doe*

28. Registrar's slip: *John Doe*

29. Registrar's form: *John Doe*

30. Registrar's paper: *John Doe*

31. Registrar's material: *John Doe*

32. Registrar's object: *John Doe*

33. Registrar's purpose: *John Doe*

34. Registrar's result: *John Doe*

35. Registrar's effect: *John Doe*

36. Registrar's action: *John Doe*

37. Registrar's power: *John Doe*

38. Registrar's authority: *John Doe*

39. Registrar's jurisdiction: *John Doe*

40. Registrar's competence: *John Doe*

41. Registrar's qualification: *John Doe*

42. Registrar's fitness: *John Doe*

43. Registrar's propriety: *John Doe*

44. Registrar's expediency: *John Doe*

45. Registrar's utility: *John Doe*

46. Registrar's benefit: *John Doe*

47. Registrar's advantage: *John Doe*

48. Registrar's improvement: *John Doe*

49. Registrar's progress: *John Doe*

50. Registrar's development: *John Doe*

51. Registrar's growth: *John Doe*

52. Registrar's expansion: *John Doe*

53. Registrar's extension: *John Doe*

54. Registrar's enlargement: *John Doe*

55. Registrar's increase: *John Doe*

56. Registrar's multiplication: *John Doe*

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72. Registrar's siting: *John Doe*

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80. Registrar's going: *John Doe*

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85. Registrar's passing: *John Doe*

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94. Registrar's attaining: *John Doe*

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97. Registrar's receiving: *John Doe*

98. Registrar's accepting: *John Doe*

99. Registrar's approving: *John Doe*

100. Registrar's agreeing: *John Doe*

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

072

(I)

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4728											
04715											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro					
c. LENGTH OF STAY IN lb 16 days						d. STREET ADDRESS					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Edith First Middle Last Simms						4. DATE OF DEATH April 5 19 61					
5. SEX Female		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8 Feb. 1926		9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Cook		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Percy Simms						14. MOTHER'S MAIDEN NAME Agnes Belt					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 20 31 24087					
17. INFORMANT Catherine Barnett						Address Upper Marlboro Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Heart Disease (a), stating the underlying cause last. (c) Anemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 Month 3 weeks											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 20 19 61 to Apr. 5 19 61, that (I) (we) last saw the deceased alive on Mar. 5 19 61, and that death occurred at 7:10 AM from the causes and on the date stated above.											
22a. SIGNATURE Peter Duus						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/6/61			
22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus, M.D.						22d. ADDRESS 6124 Central Ave., Capitol Heights, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF 4-8-61		23c. NAME OF CEMETERY OR CREMATORY Moses		23d. LOCATION (City, town or county) (State) Anne Arundel Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Rollins Funeral Home						ADDRESS 4339 Hunt Rd		25a. REC'D BY REGISTRAR DATE APR 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

1958

## CERTIFICATE OF DEATH

Reg. Dist. No. 04716

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u> c. LENGTH OF STAY IN 1b <u>1 yr. 10 mo.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cumberland</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u> d. STREET ADDRESS <u>47X-3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sophia</u> Middle <u>A.</u> Last <u>Soethe</u>		4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <u>5</u> Day <u>27</u> Year <u>1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>19</u> Min.	11. IF UNDER 24 HRS. Months <u>7</u> Days <u>10</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Copy holder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME <u>Frederick Soethe</u>		14. MOTHER'S MAIDEN NAME <u>Anna Lutzy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Penilda S. Doyle</u> Address	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Occlusion</u> DUE TO <u>Cerebral and generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 year</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2/8/61</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyelitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 10 1959</u> to <u>4/26/61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/25/61</u> , 19 <u>61</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John J. Sweeney</u> PHYSICIAN'S NAME (Type) <u>John J. Sweeney</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 29-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Pauls.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>T. F. Costello</u> ADDRESS <u>1722 NORTH EAPLEDALE</u>		24a. REC'D BY REGISTRAR <u>APR 28 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>

VS A15 (4)  
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the following information: Name of deceased, date and place of birth, date and place of death, cause of death, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the following information: Name of deceased, date and place of birth, date and place of death, cause of death, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

(M)

(1)

Exhibit April 21-61 to the Court. Dr. J. M. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AFB, MARYLAND</b> c. LENGTH OF STAY IN 1b <b>0</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>USAF Hosp, Andrews AFB, Maryland</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>OHIO</b> b. COUNTY <b>EAST CLEVELAND</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13520 SUPERIOR ROAD</b> d. STREET ADDRESS <b>13520 SUPERIOR ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LOIS A STEGKEMPER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 JULY 1908</b>
9. AGE (In years last birthday) <b>52 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MILITARY SERVICE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired United States Air Force</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>FRED STEGKEMPER</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES 15 YRS</b>		16. SOCIAL SECURITY NO. <b>PERSONAL EFFECTS AND RECORDS</b>	
17. INFORMANT <b>PERSONAL EFFECTS AND RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY HEART DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>VENTRICULAR FIBRILLATION</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>IMMEDIATE</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NUTRITIONAL CIRRHOSIS</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>this hospital</del> attended the deceased <del>at</del> ON <b>10 April, 1961</b> , that (I) <del>last</del> saw the deceased alive on <b>10 April 1961</b> , and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Gerald Resner</b> M.D.		22b. DATE SIGNED <b>10 Apr 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>GERALD RESNER, Capt USAF MC</b>		22d. ADDRESS <b>USAF Hosp, Andrews AFB, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>14 April 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>RINALDI FUNERAL HOME, INC. 816 H St. N.E.</b>		23d. LOCATION (City, town or county) (State) <b>CLEVELAND OHIO</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>RINALDI FUNERAL HOME, INC.</b>		25a. REC'D BY REGISTRAR <b>APR 12 '61</b>	
ADDRESS <b>816 H St. N.E.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

M

RECORDS SECTION

ANDREWS AFB, MARYLAND

USAF, Loop, Andrews AFB, Maryland

13240 SUPERIOR ROAD

EAST GREENLAND

CHIEF

LOIS

STECKERTON

APRIL

27 JULY 1968

REMAIL CAUCASIAN

MILITARY SERVICE

Enlisted United States Air Force

UNKNOWN

REED STECKERTON

UNKNOWN

YES IS YES

PERSONAL EFFECTS AND RECORDS

CORONARY HEART DISEASE

VERMICULAR FIBRILLATION

NUTRITIONAL CLINOSIS

1968 ON

10 April 68

1968 ON

2 A

USAF, Loop, Andrews AFB, Maryland

DETACHED SERVICE, Capt USAF

may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

4731

04718

1. PLACE OF DEATH a. COUNTY <b>Pr. Geo.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Hghts</b>				c. LENGTH OF STAY IN 1b <b>18</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5115--28th Parkway S.E.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BETTIE</b> Middle <b>L.</b> Last <b>SULLIVAN</b>				4. DATE OF DEATH Month <b>April</b> Day <b>30th</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 16, 1882</b>		9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School Teacher</b>		11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William J. Knight</b>				14. MOTHER'S MAIDEN NAME <b>Dora Eaves</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Agnes Law, 5115 28th Parkway S.E.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis Generalized Atherosclerosis</b> DUE TO (c) <b>Arteriosclerosis Generalized Atherosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>11 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-27</b> 19 <b>60</b> to <b>4-30</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4-30</b> 19 <b>61</b> , and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>John J. Calarco</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-30-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>John J. Calarco MD</b>				22d. ADDRESS <b>3801 Suitland Rd. S.E. Wash. 20.DC.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 2, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ammons Bros</b>				ADDRESS <b>1661--Good Hope Rd. S.E. Washington 20 DC</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 1 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

107

CERTIFICATE OF DEATH

1931

Blank certificate form with horizontal lines for text entry.

## CERTIFICATE OF DEATH

Reg. Dist. No.

04719

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGE MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> COUNTY <b>PRINCE GEORGE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>		c. LENGTH OF STAY IN lb <b>adm. 3-25-1961</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LAUREL SANITARIUM</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emma EMMA First Belle Middle TAVENNER Last</b>		4. DATE OF DEATH Month <b>4</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct-3-1875</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>JOHN V. TAVENNER</b>		14. MOTHER'S MAIDEN NAME <b>EMMA THOMAS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Hosp. Records</b>		Address <b>LAUREL SANITARIUM</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia (491)</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause last. (b) <b>Myocardial degeneration (422.1)</b> DUE TO (c) <b>max months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malignant neoplasm of breast (170)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-25-1961</b> to <b>4-5-1961</b> , that I last saw the deceased alive on <b>4-5-1961</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Linton P. Kraemer M.D.</b>		ADDRESS (Street, city or town, state) <b>LAUREL SANITARIUM 4-5-61</b>	
PHYSICIAN'S NAME (Type) <b>ERIKA P. KRAEMER</b>		ADDRESS (Street, city or town, state) <b>LAUREL MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/7/1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Falls Church, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE APR 6 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



WESTERN BUREAU OF INVESTIGATION  
UNITED STATES DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR  
FROM: SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

1. [Illegible]

2. [Illegible]

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99. [Illegible]

100. [Illegible]

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4733 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04720											
Item 22a, film G285 4/24/61 iwk											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BELTSVILLE</b> d. STREET ADDRESS <b>11720 ELLINGTON DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>DORA C. TAYLOR</b>						4. DATE OF DEATH <b>APRIL 14th., 1961</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 1, 1889</b>		9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>DANIEL G. GEE</b>						14. MOTHER'S MAIDEN NAME <b>CAROLINE MCGEE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service) <b>NONE</b>						16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mr. James R. Taylor</b> Address <b>Same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO (b) <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>James R. Taylor</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED <b>APRIL 15th. 1961</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>shipped</b>				22b. DATE THEREOF <b>4-18-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROANOKE Salem Corr. Graysbury N.C.</b>				22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <b>Henry Washington</b> ADDRESS <b>4925 Revere Ave N.E.</b>						24a. REC'D BY REGISTRAR <b>APR 20 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>			

THE STATE  
OF NEW YORK

(M)

(1)

TO BE RETURNED TO THE  
CLERK OF THE COURT  
IN THE COUNTY OF  
NEW YORK

IN SENATE,  
JANUARY 1, 1901.

REPORT OF THE  
COMMISSIONERS OF THE  
LAND OFFICE  
IN RESPONSE TO A  
RESOLUTION PASSED  
BY THE SENATE  
JANUARY 1, 1901.

ALBANY:  
JANUARY 1, 1901.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4734

04721

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>4 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47 Mt. Rainier</u> d. STREET ADDRESS <u>3411 Newton Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Benjamin Thomas</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>31 Aug 1960</u> 9. AGE (in years last birthday) <u>7</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>9</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Washington D. C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Nelson F Thomas</u> 14. MOTHER'S MAIDEN NAME <u>Shirley K. Williams</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Nelson F. Thomas-Father-same 2d</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelactasis of the lungs</u> <u>241X</u> DUE TO <u>Br on chad As thina</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-5</u> , 19 <u>61</u> , to <u>4-10</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4-10</u> , 19 <u>61</u> , and that death occurred at <u>7:15AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John W. Perkins</u> M.D. 22b. DATE SIGNED <u>4/9/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. John W. Perkins, md</u> 22d. ADDRESS <u>5301 Ham. Honst, Nya Hsville, md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/12/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 12 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

VR A15 (4)  
15M 9/60

3

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>Dead on Arrival</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kent Village</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>7204 Forest Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Laura Jane Thomas</b>				4. DATE OF DEATH <b>April 24th 1961</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 20, 1961</b>		9. AGE (in years last birthday) <b>1</b> <b>4</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>4</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Harry Nelson Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Latreceia Grace Bennett</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Mrs. L. G. Thomas, same as # 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute gastroenteritis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>571.0</b> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>April 24th., 1961</b>			
EXAMINER'S NAME (Type) <b>James I. Boyd, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-26-61</b>		22c. NAME OF CEMETERY OR CREMATOR <b>Arlington National</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>					
23. FUNERAL DIRECTOR <b>W. W. Chambers Co. Riverdale Md.</b>						24a. REC'D BY REGISTRAR <b>APR 26 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>			

-2050244xv5



**MARYLAND STATE DEPARTMENT OF HEALTH**  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY <b>Prince George's County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b> d. STREET ADDRESS <b>8804 Ardmore Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b> First <b>THOMSON</b> Middle Last 4. DATE OF DEATH <b>April 13, 1961</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>July 16, 1889</b> 9. AGE (In years last birthday) <b>71</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pressman (Retired)</b> 11. BIRTHPLACE (State or foreign country) <b>Linlithgow Shire, Scotland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Archibald Thomson</b> 14. MOTHER'S MAIDEN NAME <b>Susan Garvie</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>Yes, unknown</b> 17. INFORMANT <b>Mr. Edward R. Conner</b> Address <b>2745 73d Place, Hyattsville, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Coronary artery disease</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>JAMES I. BOYD, M.D.</b> EXAMINER'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>April 17, 1961</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b> 22d. LOCATION (City, town, or country) <b>Colmar Manor, Md.</b> 23. FUNERAL DIRECTOR <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b> 24a. REC'D BY REGISTRAR <b>APR 19 61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hase</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>April 14, 1961</b> Address (Street, city, town, or county)	



## CERTIFICATE OF DEATH

Reg. Dist. No. 04724

4737

1. PLACE OF DEATH o. COUNTY <u>Bruce George MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>P. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farmount Hts</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>30 Farmount Hts</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1008-60 Ave</u>				d. STREET ADDRESS <u>11008-60 Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Thompson</u>				4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1874</u>		9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ARTHUR THOMPSON</u>				14. MOTHER'S MAIDEN NAME <u>Mrs. H. M. TRICK PAIR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>Mrs. H. M. TRICK PAIR</u>		Address <u>916-60 Ave. Farmount Hts</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF PROSTATE</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HyperTension - Arterio Sclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-16</u> , 19 <u>57</u> , to <u>4-26</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4-26</u> , 19 <u>61</u> , and that death occurred at <u>11:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>H. L. Beldon</u> M.D. <u>4423 - 1st St. P. A. E.</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>H. C. Beldon, MD Washington - D. C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-1-61</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Nat Harmony</u>		22d. LOCATION (City, town, or county) (State) <u>Highland Pk. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S Washington</u>				ADDRESS <u>4925 Decade Ave</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 2 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Blank certificate form with faint horizontal lines and vertical columns for data entry.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clinton, Maryland</u>	
c. LENGTH OF STAY in 1b <u>3 days</u>		d. STREET ADDRESS <u>RT #1 Box 385</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Southern Md. Hosp. Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edgar</u> First <u>Edmond</u> Middle <u>Thorne</u> Last		4. DATE OF DEATH <u>April 4</u> Month <u>4</u> Day <u>1961</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-61</u>
9. AGE (In years last birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <u>Clinton, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <u>Carl Bernard Thorne</u>	
14. MOTHER'S MAIDEN NAME <u>Ruth Virginia Bridgett</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. (If yes give number or dates of service)		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>aspiration pneumonia</u> DUE TO (c) <u>in utero</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 1 - 1961</u> to <u>April 4, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 3, 1961</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A. Burton Mincosky</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. BURTON MINCOSKY</u>		22d. ADDRESS <u>Southern Md. Hosp Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 5 - 61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St John's</u>	23d. LOCATION (City, town or county) (State) <u>Clinton, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u> ADDRESS <u>1661-94 Hwy Rd SE</u>		25a. REC'D BY REGISTRAR DATE <u>APR 6 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hall</u>			

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may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4739

04726

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince Georges</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>        |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Beltsville, Md.</u>   |  |  |  | c. LENGTH OF STAY IN 1b <u>74</u> years <u>Beltville</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11300 Cherry Hill Rd.</u>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Trager</u> First <u>Charles</u> Middle <u>W.</u> Last <u>Trager</u>  |  |  |  | 4. DATE OF DEATH <u>April</u> Month <u>16</u> Day <u>18</u> Year <u>1961</u>   |  |  |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Aug. 9. 1891</u>   |  |
| 9. AGE (In years last birthday) <u>69</u> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min.   |  | IF UNDER 24 HRS. Months Days Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>           |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME <u>John A. Trager</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Caroline Maurer</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |  |  |  | 16. SOCIAL SECURITY NO. <u>217 36 5592</u>   |  | 17. INFORMANT <u>Mrs. Helma E. Trager (same as #2)</u> Address                 |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br><u>331X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u><br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 1/2 hours</u><br><u>54 hrs</u>        |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July</u> <u>1961</u> to <u>April 16</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>April 14</u> <u>1961</u> , and that death occurred at <u>PM</u> <u>7</u> M, from the causes and on the date stated above.  |  |  |  |  |  |  |  |
| 22a. SIGNATURE <u>James A. Whitlock</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  | 22b. DATE SIGNED <u>4-16-61</u>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>JAMES WHITLOCK</u>  |  |  |  | 22d. ADDRESS <u>7717 Carroll Ave Takoma Park Md.</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE THEREOF <u>April 20, 1961</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>   |  | 23d. LOCATION (City, town, or county) (State) <u>Prince Georges County Md.</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walker, 254 Carroll St NW DC.</u> ADDRESS   |  |  |  | 25a. REC'D BY REGISTRAR DATE <u>APR 19 '61</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>                             |  |

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TO THE DIRECTOR, BUREAU OF BACTERIOLOGY  
FROM THE CHIEF, DIVISION OF BACTERIOLOGY  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report.]

[Illegible text continues, likely containing details of the study or findings.]

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4740

04727

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>        |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>  |  |   |  | c. LENGTH OF STAY IN 1b <b>10 days</b>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>   |  |   |  | d. STREET ADDRESS <b>700 61st Avenue</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>George Travers</b>   |  |   |  | 4. DATE OF DEATH <b>April 22 19 61</b>   |  |  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>Black</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>1893 15 Oct. 1893</b>  |  |
| 9. AGE (In years last birthday) <b>67 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months Days  |  | IF UNDER 24 HRS.<br>Hours Min.   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |
| 13. FATHER'S NAME <b>Unknown</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Bertha Fenwick</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.  |  |  |  |
| 17. INFORMANT <b>Pearline Travers 1623 Holbrook St., N.E.</b>   |  |   |  | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cerebral Arteriosclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) |  |   |  |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b><br>Unknown  |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12 Apr 1961</b> to <b>22 April 19 61</b> , that (I) (we) last saw the deceased alive on <b>22 April 19 61</b> and that death occurred at <b>7:10 AM</b> from the causes and on the date stated above.  |  |   |  |  |  |  |  |
| 22a. SIGNATURE <b>Peter Duus</b> M.D.   |  |   |  | 22b. DATE SIGNED   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. Peter Duus., M.D.</b>   |  |   |  | 22d. ADDRESS <b>6124 Cenral Ave, Capitol Hghts., Md</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF <b>4/26/61</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Pumphrey Cemetery</b>  |  | 23d. LOCATION (City, town or county) (State) <b>Pumfret Md</b>                                 |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Rollins Funeral Home</b>  |  |   |  | 25a. REC'D BY REGISTRAR <b>APR 26 '61</b>  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>   |  |   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

4742  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04729

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Prince George</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>         |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>College Park</b>   |                               | c. LENGTH OF STAY IN 1b<br><b>2 Years</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>5007 Muskogee Street</b>   |                               | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>College Park</b>  |  |
| 3. NAME OF DECEASED (Type or print) <b>ALICE</b> First <b>EDITH</b> Middle <b>UFHEIL</b> Last   |                               | 4. DATE OF DEATH <b>April</b> Month <b>20</b> Day <b>1961</b> Year   |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>April 21, 1899</b> |
| 9. AGE (In years lost birthday) <b>61</b> yrs.  |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>England</b>   |                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 13. FATHER'S NAME<br><b>John Thorn</b>  |                               | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  |
| 17. INFORMANT<br><b>Mr. Fred Ufheil Same as #2 (Husband)</b>  |                               | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Sclerosis - 2 yrs</b><br>DUE TO<br>(c) <b>Superficial C-V. Dis - 10 yrs</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |                               |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                               | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10/15</b> 19 <b>35</b> to <b>4/4</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/4</b> 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.   |                               |  |  |
| 22a. SIGNATURE<br><b>J. M. Warren</b>   |                               | 22b. DATE SIGNED<br><b>4/20/61</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)  |                               | 22d. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                               | 23b. DATE THEREOF<br><b>4/25/61</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Arlington National</b>   |                               | 23d. LOCATION (City, town, or county) (State)<br><b>Arlington, Va.</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Francis Gasch's Sons</b>   |                               | 25a. REC'D BY REGISTRAR<br><b>APR 24 '61</b>   |  |
| ADDRESS<br><b>Hyattsville, Maryland</b>   |                               | 25b. REGISTRAR'S SIGNATURE   |  |

CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 7/59

FOR STATE  
HEALTH DEPT.

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4741

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04728

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George's MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)<br>a. STATE Maryland b. COUNTY Prince George's |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly Manor   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly Manor                                      |  |
| c. LENGTH OF STAY IN 1b 5 years   |  | d. STREET ADDRESS 3321 64th Avenue   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3321 64th Avenue   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 3. NAME OF DECEASED (Type or print) Edgar Ambrose Upfold  |  | 4. DATE OF DEATH April 20, 19 61   |  |
| 5. SEX Male   |  | 6. COLOR OR RACE White   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH Sept 27, 1884   |  |
| 9. AGE (in years last birthday) 76 yrs.   |  | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick layer   |  | 10b. KIND OF BUSINESS OR INDUSTRY Retired  |  |
| 11. BIRTHPLACE (State or foreign country) England   |  | 12. CITIZEN OF WHAT COUNTRY? U. S. A.  |  |
| 13. FATHER'S NAME Arthur Upfold   |  | 14. MOTHER'S MAIDEN NAME Unknown   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No  |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT Mr. Walter Edward Thomases, same as # 2   |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 442X Acute congestive heart failure<br>DUE TO (b) Cardiovascular renal disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                               |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |  |  |
| ACTUAL SIGNATURE James I. Boyd  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) James I. Boyd  |  | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
|   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> x  |  |
|   |  | DATE SIGNED April 20, 1961   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial  |  | 22b. DATE THEREOF 4/24/61  |  |
| 22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery   |  | 22d. LOCATION (City, town, or country) (State) Pr. Geo. Co., Maryland  |  |
| 23. FUNERAL DIRECTOR The S.H.Hines Co.-2901 14th St. N.W. Washington 9, D.C.  |  | 24a. REC'D BY REGISTRAR APR 24 '61   |  |
|   |  | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus   |  |

NAME: [illegible] SEX: [illegible] AGE: [illegible]  
DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]  
OCCUPATION: [illegible] MARITAL STATUS: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]  
PLACE OF DEATH: [illegible] CAUSE OF DEATH: [illegible]

IMMEDIATE CAUSE OF DEATH: [illegible]  
UNDERLYING CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]

PHYSICIAN'S SIGNATURE: [illegible]  
DATE: [illegible]

REGISTRAR'S SIGNATURE: [illegible]  
DATE: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4743

Item 9 Film G284 4/10/61 iwk

04730

|   |                              |   |   |
|---|------------------------------|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>PRINCE GEORGE</b> MARYLAND   |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br>b. COUNTY<br><b>ALEXANDRIA, VA.</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville</b>  |                              | c. LENGTH OF STAY IN 1b<br><b>3 yrs.</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>CARROLL MANOR 4422 LA SALLE RD</b>   |                              | d. STREET ADDRESS<br><b>524 HERBERT SPRINGS</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>CAROLINE C. VAN ANTWERP</b>  |                              | 4. DATE OF DEATH<br>Month Day Year<br><b>APRIL 2 1961</b>   |   |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>JUNE 26-1872</b> |
| 9. AGE (In years last birthday)<br><b>88 1/2 yrs.</b>   |                              | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>MT. STERLING Kentucky U.S.A.</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>LANDONT. CHILES</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>MARY MITCHELL</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                              | 16. SOCIAL SECURITY NO.<br><b>—</b>   |   |
| 17. INFORMANT<br><b>Sister Mary Agnes Patricia Carroll Manor</b>  |                              | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myeloblastic Leukemia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>204.1</b><br>DUE TO<br>(c) <b>2 weeks</b> |                              | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>April 1</b> 19 <b>61</b> , to <b>April 2</b> 19 <b>61</b> , that (I) (we) lost the deceased on <b>April 1</b> 19 <b>61</b> , and that death occurred at <b>10:10 A.M.</b> from the causes and on the date stated above.  |                              | 22a. SIGNATURE<br><b>John W. Trenis</b><br>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22b. DATE SIGNED<br><b>April 2, 1961</b> |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John W. Trenis</b>   |                              | 22d. ADDRESS<br><b>1150 Conn. Ave. Wash. 6, D.C.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>   |                              | 23b. DATE THEREOF<br><b>4/2/61</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY  |                              | 23d. LOCATION (City, town, or county) (State)<br><b>MT. STERLING, KENTUCKY</b>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph Lawler</b>  |                              | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 4 '61</b>  |   |
| ADDRESS<br><b>1756 Pennsylvania Ave</b>   |                              | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |   |

CERTIFICATE OF DEATH

DATE

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MD  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04731

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|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George's MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)<br>a. STATE Maryland b. COUNTY Prince George's                     |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly   |  |  |  | c. LENGTH OF STAY IN 1b D. O. A.   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital   |  |  |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville   |  |   |  |
| f. STREET ADDRESS 3804 Nicholson Street   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mary Anne Vaughn  |  |  |  | 4. DATE OF DEATH Month Day Year April 9, 1961  |  |   |  |
| 5. SEX Female   |  | 6. COLOR OR RACE White   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH November 23, 1923                              |  |
| 9. AGE (In years last birthday) 37 yrs.   |  | IF UNDER 1 YEAR Months Days  |  | IF UNDER 24 HRS. Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY Own Home   |  |   |  |
| 11. BIRTHPLACE (State or foreign country) Maryland  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? U. S. A.  |  |   |  |
| 13. FATHER'S NAME Porter De Witt  |  |  |  | 14. MOTHER'S MAIDEN NAME Lula Griffith   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No   |  |  |  | 16. SOCIAL SECURITY NO. 216 18 1457  |  |   |  |
| 17. INFORMANT Address Olin Vaughn, same as # 2  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CORONARY ARTERY THROMBOSIS<br>420.1 DUE TO (b) CORONARY ARTERY ATHEROSCLEROSIS<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                            |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE James I. Boyd  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type) James I. Boyd  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |  | DATE SIGNED April 9, 1961  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  | 22b. DATE THEREOF April 12, 1961   |  | 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery   |  | 22d. LOCATION (City, town, or county) (State) Colmar Manor, Md. |  |
| 23. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Md.   |  |  |  | 24a. REC'D BY REGISTRAR DATE APR 12 '61  |  | 24b. REGISTRAR'S SIGNATURE                                      |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04733

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|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale<br>c. LENGTH OF STAY IN 1b 2 days<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Engine Leland Memorial Hospital  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE Maryland b. COUNTY Howard<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup<br>d. STREET ADDRESS Box 121<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) Viola Irene Vallmerhausen<br>5. SEX F 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife<br>10b. KIND OF BUSINESS OR INDUSTRY Home |  | 8. DATE OF BIRTH January 27, 1892 69 yrs.<br>9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.<br>11. BIRTHPLACE (County & State, or foreign country) Howard Co. Md.<br>12. CITIZEN OF WHAT COUNTRY? USA   |  |
| 13. FATHER'S NAME Nathaniel Marcan Wheeler<br>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no<br>16. SOCIAL SECURITY NO. —  |  | 17. INFORMANT Emma Lee O'Connor<br>Address Robert M. Vallmerhausen Jessup, Md.  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>350X IMMEDIATE CAUSE (a) DUE TO Acute Myocardial Infarction<br>Conditions, if any, which gave rise to immediate cause (b) DUE TO General Cerebral Atrophy<br>(a), stating the underlying cause last. (c) DUE TO Parkinson's Disease   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>General Cerebral Atrophy  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WORK OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  | 20c. TIME OF INJURY Month, Day, Year 1960<br>Hour e.m. p.m. 19<br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) Jessup (County) Howard (State) Md.  |  |
| 21. I certify that (I) (the hospital) attended the deceased from April 8, 1960, to April 8, 1960, that (I) (the) last saw the deceased alive on April 8, 1960, and that death occurred on April 8, 1960, from the causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE Robert C. Wingfield M.D.<br>22c. PHYSICIAN'S NAME (Type) ROBERT C. WINGFIELD  |  | ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22d. ADDRESS Laurel, Maryland<br>22b. DATE SIGNED April 8, 1960   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial April 11, 1960<br>23b. DATE THEREOF<br>23c. NAME OF CEMETERY OR CREMATORY St John Lutheran Cem<br>23d. LOCATION (City, town or county) P. Pfeiffer Corner Md.   |  | 24. FUNERAL DIRECTOR'S SIGNATURE De Witt Canalehan, Laurel, Md.<br>25a. REC'D BY REGISTRAR<br>25b. REGISTRAR'S SIGNATURE<br>DATE APR 11 '61   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
4747  
CERTIFICATE OF DEATH

04734

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|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>PRINCE GEORGES</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Clinton</b><br>c. LENGTH OF STAY IN 1b<br><b>4 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Southern Md. Hosp. Center</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE<br><b>MD.</b><br>b. COUNTY<br><b>Charles Fr. Geo's</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BRANDYWINE (Rural)</b><br>d. STREET ADDRESS<br><b>Rt. 1, Box 352</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Jessie May Walton</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>April 19 1961</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>6-22-1894</b><br>9. AGE (In years last birthday)<br><b>66 yrs.</b> |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>MD.</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  | 13. FATHER'S NAME<br><b>George Ellis</b>   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Lillie Katherine Pyles Ellis</b>  |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |   |
| 16. SOCIAL SECURITY NO.<br><b>Emily Walton (Daughter-in-law)</b>   |                                  | 17. INFORMANT<br><b>Emily Walton</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b><br><b>420.1</b> DUE TO <b>Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>Uremia</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes mellitus</b> |                                  |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/18</b> , 19 <b>61</b> , to <b>4/14</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/19</b> , 19 <b>61</b> , and that death occurred at <b>5:45</b> A.M. from the causes and on the date stated above.   |                                  |  |   |
| 22a. SIGNATURE<br><b>Alfred R. Lapin, M.D.</b>   |                                  | 22b. DATE SIGNED<br><b>4/19/61</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR. A. R. LAPIN, M.D.</b>   |                                  | 22d. ADDRESS<br><b>Southern Md. Hosp. Center, Clinton, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>4/22/61</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedarville Full Gospel Cem.</b>   |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Cedarville Md.</b>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Ritchie Bros. Fun'l Home-Upper Marlboro,</b>  |                                  | 25. REC'D BY REGISTRAR<br><b>MAY 1 '61</b>   |   |
| 25a. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>   |                                  | 25b. REGISTRAR'S SIGNATURE   |   |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

| MAY 2 '61  |  |   |  |  |   |   |  |  |  |
|--|--|---|--|--|---|---|--|--|--|
| <p><b>1. PLACE OF DEATH</b><br/>e. COUNTY <b>Prince George's</b> <b>MARYLAND</b></p>   |  |   |  |  |   |   |  |  |  |
| <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br/><b>T. B.</b></p>   |  |   |  |  | <p>c. LENGTH OF STAY IN 1b<br/><b>D.O.A.</b></p>  |   |  |  |  |
| <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br/><b>Dobson Clinic</b></p>   |  |   |  |  |   |   |  |  |  |
| <p><b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br/>e. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b></p>  |  |   |  |  |   |   |  |  |  |
| <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br/><b>T. B.</b></p>   |  |   |  |  | <p>d. STREET ADDRESS<br/><b>Floral Park Road</b></p>  |   |  |  |  |
| <p>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>  |  |   |  |  |   |   |  |  |  |
| <p><b>3. NAME OF DECEASED</b> (Type or print)<br/>First <b>Charles</b> Middle <b>Edward</b> Last <b>Watson</b></p>   |  |   |  |  |   |   |  |  |  |
| <p><b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>25</b> Year <b>19 61</b></p>  |  |   |  |  |   |   |  |  |  |
| <p><b>5. SEX</b><br/><b>Male</b></p>   |  | <p><b>6. COLOR OR RACE</b><br/><b>Colored</b></p> |  | <p><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br/>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> |   | <p><b>8. DATE OF BIRTH</b><br/><b>Aug. 10, 1904</b></p>                     |  | <p><b>9. AGE</b> (In years last birthday) <b>56</b> yrs.<br/>IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/><br/>IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/></p> |  |
| <p><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br/><b>Laborer</b></p>   |  |   |  | <p><b>10b. KIND OF BUSINESS OR INDUSTRY</b><br/><b>U.S. Gov't</b></p>  |   | <p><b>11. BIRTHPLACE</b> (State or foreign country)<br/><b>Maryland</b></p> |  | <p><b>12. CITIZEN OF WHAT COUNTRY?</b><br/><b>U.S.A.</b></p>   |  |
| <p><b>13. FATHER'S NAME</b><br/><b>Frederick M. Watson</b></p>   |  |   |  |  | <p><b>14. MOTHER'S MAIDEN NAME</b><br/><b>Julia Dent</b></p>  |   |  |  |  |
| <p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)</p>   |  |   |  |  | <p><b>16. SOCIAL SECURITY NO.</b> <b>218-05-8455</b></p>  |   |  |  |  |
| <p><b>17. INFORMANT</b> <b>Georgie A. Wilson, Same as #2</b> Address</p>   |  |   |  |  |   |   |  |  |  |
| <p><b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br/>PART I. DEATH WAS CAUSED BY:<br/>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br/>420-1 DUE TO<br/>Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Artery Disease</b><br/>(c) DUE TO<br/>(e), stating the underlying cause last.<br/>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</p> |  |   |  |  |   |   |  |  |  |
| <p>INTERVAL BETWEEN ONSET AND DEATH</p>  |  |   |  |  |   |   |  |  |  |
| <p><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>   |  |   |  |  |   |   |  |  |  |
| <p><b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b></p>  |  |   |  |  | <p><b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)</p> |   |  |  |  |
| <p><b>20c. TIME OF INJURY</b> Month, Day, Year<br/>Hour e.m. p.m. <b>19</b></p>  |  |   | <p><b>20d. INJURY OCCURRED</b> While et work <input type="checkbox"/> Not While et work <input type="checkbox"/></p> |  | <p><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)</p>                      |   | <p><b>20f. (City or town)</b> (County) (State)</p>                                   |  |  |
| <p><b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>                             |  |   |  |  |   |   |  |  |  |
| <p><b>ACTUAL SIGNATURE</b> <i>James I. Boyd</i> <b>M.D.</b></p>  |  |   |  |  | <p><b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/></p>   |   |  |  |  |
| <p><b>EXAMINER'S NAME</b> (Type) <b>James I. Boyd, M.D.</b></p>  |  |   |  |  | <p><b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/></p>   |   |  |  |  |
| <p><b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/></p>  |  |   |  |  | <p><b>DATE SIGNED</b> <b>April 25, 1961</b></p>   |   |  |  |  |
| <p>Address (Street, city, town, or county)</p>   |  |   |  |  |   |   |  |  |  |
| <p><b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br/><b>Burial</b></p>  |  |   | <p><b>22b. DATE THEREOF</b><br/><b>Apr. 29/61</b></p>  |  | <p><b>22c. NAME OF CEMETERY OR CREMATORY</b><br/><b>St. Peters</b></p>                                    |   | <p><b>22d. LOCATION</b> (City, town, or country) (State)<br/><b>Waldorf, Md.</b></p> |  |  |
| <p><b>23. FUNERAL DIRECTOR</b><br/><b>George G. Nelson</b></p>   |  |   |  |  | <p><b>24a. REC'D BY REGISTRAR</b> <b>Aguarros, Md.</b></p>  |   |  |  |  |
| <p><b>24b. REGISTRAR'S SIGNATURE</b></p>   |  |   |  |  | <p><b>24c. REGISTRAR'S SIGNATURE</b></p>  |   |  |  |  |



UNITED STATES DEPARTMENT OF HEALTH

OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC HEALTH

WASHINGTON, D. C. 20495

DATE: \_\_\_\_\_

TO: \_\_\_\_\_

FROM: \_\_\_\_\_

SUBJECT: \_\_\_\_\_

RE: \_\_\_\_\_

REFERENCE: \_\_\_\_\_

ATTENTION: \_\_\_\_\_

ADMINISTRATIVE: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

MAIL ROOM: \_\_\_\_\_

RECORDS SECTION: \_\_\_\_\_

GENERAL INVESTIGATIVE DIVISION: \_\_\_\_\_

LABORATORY: \_\_\_\_\_

LEGAL COUNSEL: \_\_\_\_\_

PLANNING AND EVALUATION: \_\_\_\_\_

COMMUNITY RELATIONS: \_\_\_\_\_

ADMINISTRATIVE SERVICES: \_\_\_\_\_

OTHER: \_\_\_\_\_

APPROVED: \_\_\_\_\_

SPECIAL AGENT IN CHARGE

UNITED STATES DEPARTMENT OF HEALTH

OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC HEALTH

WASHINGTON, D. C. 20495

DATE: \_\_\_\_\_

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |  |  |  |  |
|---|--|--|--|---|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |   |   |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |  |  |
| Item 8 & 9 Film G286 5/12/61 iwk  |  |  |  |   |   |  |  |  |  |
| 04736   |  |  |  |   |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Georges</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Riverdale, Maryland</b><br>c. LENGTH OF STAY IN 1b<br><b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Eugene Leland Memorial</b>  |  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince Georges</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>6201 Pontiac Street</b><br>d. STREET ADDRESS<br><b>College Park, Maryland</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Margaret Mabel Willard</b>   |  |  |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>April 27 19 61</b>   |  |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>                     |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>7/25/89 1877</b>                                  |  | 9. AGE (In years last birthday)<br><b>83 82 yrs.</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b> |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>United States</b> |  |  |
| 13. FATHER'S NAME<br><b>?</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Marie Hayes</b>  |   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>(I)</b>   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>?</b>   |   | 17. INFORMANT<br><b>Mrs Roberta Hill College Park, Md.</b>               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e)<br><b>4200</b> DUE TO <b>Acute Biliary Edema</b><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.<br>(b) <b>Arterio-sclerotic Heart Disease</b><br>(c) <b>no decompensation</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>Broncho pneumonia, Bilat.</b><br>INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |   |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |   |  |  |  |  |
| MEDICAL CERTIFICATION<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY<br>Hour e.m. p.m. Month, Day, Year<br><b>19</b><br>20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br><b>4/14/61</b><br><b>4/27/61</b> |  |  |  |   |   |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4/14/61</b> to <b>4/27/61</b> , that (I) <b>(*)</b> last saw the deceased alive on <b>4/27/61</b> , and that death occurred <b>2:25 PM</b> , from the causes and on the date stated above.   |  |  |  |   |   |  |  |  |  |
| 22a. SIGNATURE<br><b>W.L. Etienne</b><br>M.D.<br>22c. PHYSICIAN'S NAME (Type)<br><b>W.L. ETIENNE</b>  |  |  |  |   | 22b. DATE SIGNED<br><b>4/27/61</b><br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22d. ADDRESS<br><b>College Park, Md</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>May 1, 1961</b>              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>  |   | 23d. LOCATION (City, town or county) (State)<br><b>Colmar Manor, Md.</b> |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. Gasch's Sons</b>  |  |  |  | ADDRESS<br><b>Hyattsville, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>MAY 1 '61</b>                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b> |  |

0435

0435

①

Mr. Robert Hill College Park, Md.

Dear Mr. Hill:

I have just received your letter of the 12th inst. regarding the matter of the 1954-55 season.

I am sorry to hear that you are having trouble with the 1954-55 season. I am sure that you will be able to handle it in the best possible manner.

I am sure that you will be able to handle it in the best possible manner. I am sure that you will be able to handle it in the best possible manner.

I am sure that you will be able to handle it in the best possible manner. I am sure that you will be able to handle it in the best possible manner.

may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate should be detached for use on the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
4750

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04737

|   |                               |  |                                     |  |                             |   |   |
|---|-------------------------------|--|-------------------------------------|--|-----------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE GEORGE</u> MARYLAND  |                               |  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u> |                             |   |   |
| 5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITHAND</u>  |                               |  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITHAND</u>   |                             |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3202- RYAN DRIVE</u>  |                               |  |                                     | d. STREET ADDRESS <u>13202 RYAN DRIVE</u>  |                             |   |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                     |  |                             |   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>GERTRUDE MAY WILSON</u>  |                               |  |                                     | 4. DATE OF DEATH Month Day Year <u>APRIL 8 1961</u>  |                             |   |   |
| 5. SEX <u>FEMALE</u>  | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 8-1907</u> | 9. AGE (In years lost birthday) <u>53</u> yrs.   | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>   |                               |  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY  |                             | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>               |   |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |                               |  |                                     |  |                             |   |   |
| 13. FATHER'S NAME <u>CHARLES H. WILSON</u>  |                               |  |                                     | 14. MOTHER'S MAIDEN NAME <u>DAISY P. ROBEY</u>   |                             |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)   |                               |  |                                     | 16. SOCIAL SECURITY NO. <u>NONE</u>  |                             | 17. INFORMANT <u>CHARLES H. WILSON</u> Address <u>#19 PARKLAND AVE</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Exhaustion</u><br><u>355X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Cerebral Cortical Atrophy</u> DUE TO<br>(c) <u>25 years</u> |                               |  |                                     |  |                             |   | INTERVAL BETWEEN ONSET AND DEATH <u>week</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |  |                                     |  |                             |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                             |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                             | 20f. (City or town) (County) (State)                                    |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1940</u> to <u>April 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 7, 1961</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.   |                               |  |                                     |  |                             |   |   |
| 22a. SIGNATURE <u>James I. Boyd</u>   |                               |  |                                     | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>           |                             | 22b. DATE SIGNED <u>Washington 28 DC</u>                                |   |
| 22c. PHYSICIAN'S NAME (Type) <u>JAMES I. BOYD</u>   |                               |  |                                     | 22d. ADDRESS <u>8200 MARBORO PIKE SE</u>   |                             |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE THEREOF <u>4/11/61</u>   |                                     | 23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>   |                             | 23d. LOCATION (City, town, or county) (State) <u>SUITHAND, P.G. MD.</u> |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>SIMMONS BROS</u> ADDRESS <u>1601 GOOD HOPE ROAD S.E. D.C.</u>   |                               |  |                                     | 25a. REC'D BY REGISTRAR DATE <u>APR 11 '61</u>   |                             | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>                       |   |

1950

(1)

NAME  
JAMES  
JAMES

DATE OF BIRTH  
JAN 1 1892

PLACE OF BIRTH  
NEW YORK

CERTIFICATE NO.  
10000

DATE OF DEATH  
JULY 8 1950

AGE  
58

CAUSE OF DEATH  
DISEASE OF THE HEART

NO

WIFE

CHARLES H. WILSON

Signature of Registrar  
JAMES H. WILSON  
Signature of Physician  
JAMES H. WILSON

1  
 4751  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 04738

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Camp Springs</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Camp Springs</b>  |   |
| c. LENGTH OF STAY IN 1b<br><b>1 DAY 23 HRS</b>  |   | d. STREET ADDRESS<br><b>5213 Colonial Drive</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>USAF HOSPITAL, ANDREWS AFB</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JAMES</b> Middle <b>W</b> Last <b>WILSON</b>  |   | 4. DATE OF DEATH<br>Month <b>APRIL</b> Day <b>15</b> Year <b>1961</b>  |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>CAUC</b>           | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>22 Feb 1961</b>                                |
| 9. AGE (In years lost birthday) yrs.<br><b>1</b> Months <b>23</b> Days <b>15</b> Hours <b>15</b> Min.   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |   |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |   | 13. FATHER'S NAME<br><b>JAMES L. WILSON</b>  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>ELIZABETH JACKSON</b>  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   |
| 16. SOCIAL SECURITY NO.<br><b>N/A</b>   |   | 17. INFORMANT<br><b>JAMES L. WILSON</b> Address <b>Same as deceased</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>422.2 Congestive heart failure</b><br>DUE TO (b) <b>Coronary heart disease myocarditis</b><br>DUE TO (c) <b>Myocarditis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b>                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   | 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |   |
| 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   |
| 20f. (City or town) (County) (State)  |   | 21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>14 April 1961</b> to <b>15 April 1961</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>15 April 1961</b> , and that death occurred at <b>0459</b> , from the causes and on the date stated above. |   |
| 22a. SIGNATURE<br><b>John A. Moore</b>  |   | 22b. DATE SIGNED<br><b>15 APRIL 1961</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JOHN A. MOORE, MAJOR USAF MC</b>   |   | 22d. ADDRESS<br><b>USAF HOSPITAL ANDREWS AFB, WASH 25, D.C.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL, (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>18 April 1961</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON NATIONAL</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>ARLINGTON VA.</b> |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Rinaldi Funeral Home Inc.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>APR 18 1961</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>   |   | 25c. DATE<br><b>APR 18 1961</b>  |   |

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CERTIFICATE OF DEATH

(M)

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

(T)

11. Name of informant: [illegible]  
12. Address of informant: [illegible]  
13. Signature of informant: [illegible]  
14. Date of completion: [illegible]

15. Remarks: [illegible]  
16. Signature of registrar: [illegible]  
17. Date of registration: [illegible]  
18. Signature of registrar: [illegible]  
19. Date of registration: [illegible]  
20. Signature of registrar: [illegible]  
21. Date of registration: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04739

4752

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY Prince Georges MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE D. C. b. COUNTY -                                      |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)   |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington  |  |   |  |
| c. LENGTH OF STAY IN 1b 18 days   |  |  |  | d. STREET ADDRESS 1221 H. St., N. E.   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last Oscar - Wilson  |  |  |  | 4. DATE OF DEATH Month Day Year 4 7 19 61  |  |   |  |
| 5. SEX Male   |  | 6. COLOR OR RACE Negro   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH 1/8/09                                   |  |
| 9. AGE (In years last birthday) 52 yrs.   |  | IF UNDER 1 YEAR Months Days  |  | IF UNDER 24 HRS. Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY Unknown  |  | 11. BIRTHPLACE (County & State, or foreign country) S. C. |  |
| 12. CITIZEN OF WHAT COUNTRY USA   |  |  |  |  |  |   |  |
| 13. FATHER'S NAME Wallace S. Wilson   |  |  |  | 14. MOTHER'S MAIDEN NAME Elizabeth Green   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No  |  |  |  | 16. SOCIAL SECURITY NO. Unknown (lost)   |  | 17. INFORMANT Decedent                                    |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulmonary Actinomycosis<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(e), stating the underlying cause last. DUE TO (c)<br>Glomerulonephritis with Uremia; Diabetes Mellitus, mild |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH 2 months                 |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                      |  |
| 21. I certify that (I) (this hospital) attended the deceased from 3/20/1961 to 4/7/1961, that (I) (we) last saw the deceased alive on 4/7/1961, and that death occurred at p.m., from the causes and on the date stated above.  |  |  |  |  |  |   |  |
| 22a. SIGNATURE Moe Weiss  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22b. DATE SIGNED 4/7/61                                   |  |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.  |  |  |  | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF 4-9-61   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City, town or county) (State) Camden S.C.  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE O.D. Hall (A.E. Washington) ADDRESS 651 E. Ave New   |  |  |  | 25a. REC'D BY REGISTRAR DATE APR 11 '61  |  | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                        |  |  |   |                               |  |                                    |  |   |  |  |  |  |                  |  |  |  |  |
|--|--|------------------------|--|--|---|-------------------------------|--|------------------------------------|--|---|--|--|--|--|------------------|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                        |  |  |   |                               |  |                                    |  |   |  |  |  |  |                  |  |  |  |  |
| 4753 Items 8, 13, 14 & 17 Film G285 5/20/61 ink 04740  |  |                        |  |  |   |                               |  |                                    |  |   |  |  |  |  |                  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY Prince Georges MARYLAND   |  |                        |  |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>e. STATE Maryland b. COUNTY Prince Georges |                               |  |                                    |  |   |  |  |  |  |                  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly  |  |                        |  |  | c. LENGTH OF STAY IN 1b 1/2 hr  |                               |  |                                    |  |   |  |  |  |  |                  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital   |  |                        |  |  | d. STREET ADDRESS Hillcrest Heights 5502 26th Ave.  |                               |  |                                    |  |   |  |  |  |  |                  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) Jacob  |  |                        |  |  | 4. DATE OF DEATH April 9 19 61  |                               |  |                                    |  |   |  |  |  |  |                  |  |  |  |  |
| 5. SEX Male  |  | 6. COLOR OR RACE White |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH May 27, 1887 |  | 9. AGE (In years last birthday) 73 |  |   |  |  |  |  |                  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired  |  |                        |  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |                               |  |                                    |  | 11. BIRTHPLACE (County & State, or foreign country) Germany   |  |  |  |  |                  |  |  |  |  |
| 13. FATHER'S NAME Unknown Jacob W. Wirz  |  |                        |  |  | 14. MOTHER'S MAIDEN NAME Unknown Wilhelmina Oelfin  |                               |  |                                    |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Navy  |  |  |  |  |                  |  |  |  |  |
| 16. SOCIAL SECURITY NO. 578-09-1045  |  |                        |  |  | 17. INFORMANT Wilmer Olson-daughter/5502-28th Ave Wilma 2600 Fairlawn St. S.E.  |                               |  |                                    |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute pulm. edema<br>420.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) Arterio sclerotic 14th dis.<br>(c) DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |                  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                        |  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |                               |  |                                    |  | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  |  |  |  |  |                  |  |  |  |  |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                        |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               |  |                                    |  | 20f. (City or town) (County) (State)  |  |  |  |  |                  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from June 1960, to April 1961, that (I) (we) last saw the deceased alive on 4-10-61, and that death occurred at 1:10A from the causes and on the date stated above. |  |                        |  |  |   |                               |  |                                    |  | 22a. SIGNATURE Lewis Parker M.D.  |  |  |  |  | 22b. DATE SIGNED |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) Dr. C.L. Parker   |  |                        |  |  | 22d. ADDRESS 5241 St. Barnabas Rd. Temple Hills, Md.  |                               |  |                                    |  | 23a. NAME OF CEMETERY OR CREMATORY Congressional Cem  |  |  |  |  |                  |  |  |  |  |
| 23b. DATE THEREOF 4-12-61  |  |                        |  |  | 23c. LOCATION (City, town or county) Washington, D.C.   |                               |  |                                    |  | 23d. (State)  |  |  |  |  |                  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE J. Wm. Lee Soma - 300 4th ST, N.E. D. C.  |  |                        |  |  | 25a. REC'D BY REGISTRAR DATE APR 13 '61   |                               |  |                                    |  | 25b. REGISTRAR'S SIGNATURE Arthur L. Haines   |  |  |  |  |                  |  |  |  |  |

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NAVY

Germany

Unknown

528-09-1045 William Olson - daughter 5502 - 28th Ave

Congressional Dem

Washington, D.C.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04741

|   |  |   |  |  |                |  |  |   |                            |   |   |               |
|---|--|---|--|--|----------------|--|--|---|----------------------------|---|---|---------------|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Adelphi</u><br>c. LENGTH OF STAY IN 1b <u>5 month + 11 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Paint Branch Nursing Home</u>   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>District of Columbia</u><br>b. COUNTY <u>Wash D.C.</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wash D.C.</u><br>d. STREET ADDRESS <u>918 - Madison St. N.W.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                |  |  |   |                            |   |   |               |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><u>John Theodore Wittstatt</u>   |  | <b>4. DATE OF DEATH</b><br>Last <u>April</u> 21 19 <u>61</u>  |  | <b>5. SEX</b><br><u>Male</u>   |                |  |  |   |                            |   |   |               |
| <b>6. COLOR OR RACE</b><br><u>White</u>   |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><u>Dec 26, 1875</u>   |                |  |  |   |                            |   |   |               |
| <b>9. AGE</b> (In years last birthday) <u>85</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>   |  | IF UNDER 1 YEAR   | IF UNDER 24 HRS.   | Months   | Days           | Hours  | Min.   | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Policeman</u> |                            | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Annapolis Md</u> |   |               |
| IF UNDER 1 YEAR   | IF UNDER 24 HRS.   |   |  |  |                |  |  |   |                            |   |   |               |
| Months  | Days   |   |  |  |                |  |  |   |                            |   |   |               |
| Hours   | Min.   |   |  |  |                |  |  |   |                            |   |   |               |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>  |  | <b>13. FATHER'S NAME</b><br><u>Peter Wittstatt</u>  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Barbara Gartzel</u>  |                |  |  |   |                            |   |   |               |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>None</u>   |  | <b>17. INFORMANT</b><br><u>Paint Nursing Home Records</u>  |                |  |  |   |                            |   |   |               |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br><table border="1" style="width: 100%;"> <tr> <td colspan="2"> <b>PART I. DEATH WAS CAUSED BY:</b><br/> <b>IMMEDIATE CAUSE (a)</b> <u>Carcinoma, Autum, Left.</u> </td> <td rowspan="3"> <b>INTERVAL BETWEEN ONSET AND DEATH</b><br/> <u>9 mos.</u> </td> </tr> <tr> <td> <b>160.2</b> </td> <td> <b>DUE TO</b> </td> </tr> <tr> <td> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> </td> <td> <b>DUE TO</b> </td> </tr> </table>   |  |   |  |  |                | <b>PART I. DEATH WAS CAUSED BY:</b><br><b>IMMEDIATE CAUSE (a)</b> <u>Carcinoma, Autum, Left.</u> |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>9 mos.</u>  | <b>160.2</b>               | <b>DUE TO</b>   | <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> | <b>DUE TO</b> |
| <b>PART I. DEATH WAS CAUSED BY:</b><br><b>IMMEDIATE CAUSE (a)</b> <u>Carcinoma, Autum, Left.</u>  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>9 mos.</u>  |  |  |                |  |  |   |                            |   |   |               |
| <b>160.2</b>  | <b>DUE TO</b>  |   |  |  |                |  |  |   |                            |   |   |               |
| <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>   | <b>DUE TO</b>  |   |  |  |                |  |  |   |                            |   |   |               |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>  |  |   |  |  |                |  |  |   |                            |   |   |               |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |                |  |  |   |                            |   |   |               |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)<br><b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <table border="1" style="width: 100%;"> <tr> <td> <b>20c. TIME OF INJURY</b><br/>                     Month, Day, Year<br/>                     Hour a.m. p.m.                 </td> <td> <b>20d. INJURY OCCURRED</b><br/>                     While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> </td> <td> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)                 </td> <td> <b>20f. (City or town)</b> </td> <td> <b>(County)</b> </td> <td> <b>(State)</b> </td> </tr> </table> |  |   |  |  |                | <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. p.m.                                 | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   | <b>20f. (City or town)</b> | <b>(County)</b>   | <b>(State)</b>  |               |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. p.m.  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   | <b>20f. (City or town)</b>   | <b>(County)</b>  | <b>(State)</b> |  |  |   |                            |   |   |               |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>August 30, 1961</u> <b>to</b> <u>April 21, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>March 30, 1961</u> <b>and that death occurred at</b> <u>7:00 P.M.</u> <b>from the causes and on the date stated above.</b>   |  |   |  |  |                |  |  |   |                            |   |   |               |
| <b>22a. SIGNATURE</b><br><u>Philip H. Philbin</u>   |  |   | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>DATE SIGNED</b> <u>4-21-61</u> |  |                |  |  |   |                            |   |   |               |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>Philip H. Philbin</u>   |  |   | <b>22d. ADDRESS</b><br><u>1302 18th ST. N.W. D.C.</u>  |  |                |  |  |   |                            |   |   |               |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>4-25-61</u>  |  | <b>23b. DATE THEREOF</b><br><u>4-25-61</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Prospect Hill</u>  |                |  |  |   |                            |   |   |               |
| <b>23d. LOCATION</b> (City, town or county)<br><u>WASHINGTON DC</u>   |  | <b>(State)</b>  |  |  |                |  |  |   |                            |   |   |               |
| <b>24 FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Namothy Haulon</u>   |  |   | <b>ADDRESS</b><br><u>3831 - 24 Ave N.W.</u>  |  |                |  |  |   |                            |   |   |               |
| <b>25a. REC'D BY REGISTRAR</b><br>DATE <u>MAY 5 '61</u>   |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Kraus</u>   |  |  |                |  |  |   |                            |   |   |               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

Prince George

Royal College

Prince George, British Columbia

John

Theodore

Male

Police

Peter

Barbara

Wife of

Barbara

Barbara

Barbara

Barbara

Barbara

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4755

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04742

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY Prince Georges   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Prince Georges                         |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Suitland  |  | c. LENGTH OF STAY IN 1b<br>6 years  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Suitland  |  | d. STREET ADDRESS<br>5633- Shady Side Ave                             |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>5633- Shady Side Ave  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>Carl Eugene Walcott   |  | First Middle Last   |  | 4. DATE OF DEATH<br>April 6 1961  |  | Month Day Year  |  |
| 5. SEX<br>male  |  | 6. COLOR OR RACE<br>white   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>Jan 26, 1922                                      |  |
| 9. AGE (In years last birthday)<br>39 yrs.  |  | IF UNDER 1 YEAR<br>Months Days  |  | IF UNDER 24 HRS.<br>Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Contractor   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Electrician  |  | 11. BIRTHPLACE (State or foreign country)<br>District of Columbia   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                |  |
| 13. FATHER'S NAME<br>Carl Horney Walcott  |  |   |  | 14. MOTHER'S MAIDEN NAME<br>Emmie Eicher  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>yes   |  | 16. SOCIAL SECURITY NO.<br>(If yes give number of service)<br>578-14-8539   |  | 17. INFORMANT<br>Mrs Mary Walcott, same as #2   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hemorrhage and shock<br>976X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) Gun shot wound of chest<br>(a), stating the underlying cause last. DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>Shot self through chest with 22 caliber |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. 10:30 p.m. 4-6 1961  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>                    |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>Home  |  | 20f. (City or town) Suitland (County) Prince Georges (State) Md       |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE James T. Boyd  |  |   |  | M.D.  |  | DATE SIGNED 4-6-61  |  |
| EXAMINER'S NAME (Type)<br>JAMES T. BOYD   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 22b. DATE THEREOF<br>April 11-61  |  | 22c. NAME OF CEMETERY OR CREMATORY<br>Arlington National  |  | 22d. LOCATION (City, town, or country) (State)<br>Arlington, Virginia |  |
| 23. FUNERAL DIRECTOR<br>Simmons Bros  |  |   |  | ADDRESS<br>1661-40 Hope Rd SE   |  | 24a. REC'D BY REGISTRAR<br>DATE APR 10 '61                            |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Kraus   |  |   |  |

Wash 20 DC

10-3-48

RECEIVED THE MEDICAL DEPARTMENT OF THE ARMY

10-3-48

THE STATE  
HOSPITAL

(M)

(1)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4756

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04743

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George's MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE Maryland b. COUNTY Baltimore |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore                                     |  |
| c. LENGTH OF STAY IN 1b Dead on arrival  |  | d. STREET ADDRESS 2923 Arma Avenue   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |
| 3. NAME OF DECEASED (Type or print) William Dewey Womack   |  | 4. DATE OF DEATH April 27th, 19 61   |  |
| 5. SEX Male  |  | 6. COLOR OR RACE Colored   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH March 17, 1926 35 yrs.  |  |
| 9. AGE (In years last birthday) 35   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver                          |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transit Co.  |  | 11. BIRTHPLACE (State or foreign country) Virginia   |  |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A.  |  | 13. FATHER'S NAME William D. Womack  |  |
| 14. MOTHER'S MAIDEN NAME Evelyn Womack   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW 11  |  |
| 16. SOCIAL SECURITY NO. WW 11  |  | 17. INFORMANT Mrs Bessie Oomack, same as # 2   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Comminuted fractures of both legs and thighs<br>(b) Crushed chest<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Driver of an automobile that was in an head on collision  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                   |  |
| 20c. TIME OF INJURY Month, Day, Year 8:25 p.m. 4/27/61   |  | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work              |  |
| 20e. PLACE OF INJURY (Home, farm, factory, shop, office bldg., etc.) Highway   |  | 20f. (City or town) Muirkirk P. G. Md  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE James I. Boyd   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |  | 22b. DATE THEREOF 5-3-61   |  |
| 22c. NAME OF CEMETERY OR CREMATORY New Bethel  |  | 22d. LOCATION (City, town, or country) Donville Va   |  |
| 23. FUNERAL DIRECTOR Thoy O Wilson   |  | 24a. REC'D BY REGISTRAR DATE MAY 5 '61   |  |
| ADDRESS 1350 Sootley Ave   |  | 24b. REGISTRAR'S SIGNATURE   |  |



**1**  
**FOR STATE**  
**HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Item 9 - film G285

4/24/61 iwk

04734

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>   |  |   |  |
| c. LENGTH OF STAY in 1b <u>2 years</u>   |  |   |  | d. STREET ADDRESS <u>1229 Maryland Ave</u>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>229 Maryland Ave</u>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>John Sylvester Yeagley</u>  |  |   |  | 4. DATE OF DEATH <u>April 19 1961</u>  |  |   |  |
| 5. SEX <u>male</u>   |  | 6. COLOR OR RACE <u>white</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <u>Dec 30, 1904</u>  |  |
| 9. AGE (In years, last birthday) <u>55</u>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>                     |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  | 13. FATHER'S NAME <u>Unknown</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes 1920</u> |  |
| 16. SOCIAL SECURITY NO. <u>578-09-3125</u>   |  | 17. INFORMANT <u>George Herbert</u>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>Coronary Artery Disease</u><br>(c) <u>Coronary Artery Disease</u> |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m. <u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>James T Boyd</u> M.D.  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| DEPUTY MEDICAL EXAMINER <u>James T Boyd</u>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| NAME (Type)  |  |   |  | DATE SIGNED <u>4-19-61</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 22b. DATE THEREOF <u>4-21-61</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl</u>   |  | 22d. LOCATION (City, town, or country) (State) <u>28 Mayer, Va</u>                |  |
| 23. FUNERAL DIRECTOR <u>R. A. Mattingly</u> ADDRESS <u>131-11th St. S.E. Wash. D.C.</u>  |  |   |  | 24a. REC'D BY REGISTRAR <u>APR 20 '61</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>                                 |  |

MEDICAL CERTIFICATION

DEPT OF STATE  
WASHINGTON

(M)

(1)

RECEIVED  
JAN 12 1942  
U.S. DEPT. OF STATE  
WASHINGTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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084

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY Prince Georges MARYLAND   |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE Maryland b. COUNTY Prince Georges |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton   |  |  |  | c. LENGTH OF STAY IN 1b 2 days   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aquasco  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Southern Maryland Hospital Center   |  |  |  |  |  | d. STREET ADDRESS   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) Walter S. Young  |  |  |  |  |  | 4. DATE OF DEATH April 13 1961  |  |  |  |  |  |
| 5. SEX male  |  | 6. COLOR OR RACE white   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH Feb. 9, 1880   |  | 9. AGE (In years last birthday) 81 yrs.  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY Farming  |  |   |  | 11. BIRTHPLACE (Country & State, or foreign country) Aquasco, Maryland                         |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |
| 13. FATHER'S NAME Joseph Henry Young   |  |  |  |  |  | 14. MOTHER'S MAIDEN NAME Margaret Virginia Gibbons  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO   |  |  |  | 16. SOCIAL SECURITY NO. 217-36-6591  |  | 17. INFORMANT Charles W. Young  |  | Address Aquasco, Md.   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis<br>Conditions, if any, which gave rise to immediate cause (b) Cardiovascular Disease<br>(c) Arteriosclerosis generalized<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (e) 3 day 4 yrs<br>Thrombosis |  |  |  |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |  |  |
| 20c. TIME OF INJURY Hour e.m. p.m. 19  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from July 1945 to April 13, 1961; that (I) (we) last saw the deceased alive on April 12, 1961, and that death occurred at 4:30 P.M. from the causes and on the date stated above.   |  |  |  |  |  |   |  |  |  |  |  |
| 22a. SIGNATURE Alfred R. Lapin M.D.  |  |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>     |  | 22b. DATE SIGNED   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN, MD   |  |  |  |  |  | 22d. ADDRESS Clinton, Md  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |  | 23b. DATE THEREOF 4-15-61  |  | 23c. NAME OF CEMETERY OR CREMATORY St Marys  |  | 23d. LOCATION (City, town or county) Aquasco, Md.   |  | (State)  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.   |  |  |  |  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR APR 18 '61   |  | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus   |  |

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